Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 26 November 2025
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Employee of the Month (November 2025)** *Purpose: To **note** the Employee of the Month presentations for November 2025*	Film	Chair *(10 mins)*
10.10	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.25	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**TB25/085 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 29 October 2025*	Report	
	6.	**TB25/086 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
10.35	7.	**TB25/087 Integrated Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report*	Report	S O'Brien / S Dowson L Neary M Szpakowska G Lawrence *(30 mins)*

Committee Assurance Reports				
11.05	8.	**TB25/088 Committee Assurance Reports** 8.1. Executive Committee 8.2. Audit Committee (including 2024/25 Audit Letter Sign Off) 8.3. Charitable Funds Committee (including Accounts and Annual Report) 8.4. Quality Committee 8.5. Strategic People Committee 8.6. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	R Cooper S Connor G Brown C Elliott L Knight C Spencer *(40 mins)*
Other Board Reports				
11.45	9.	**TB25/089 2025/26 Trust Objectives Mid-Year Review** *Purpose: To **note** the 2025/26 Trust Objectives Mid-Year Review*	Report	R Cooper *(15 mins)*
12.00	10.	**TB25/090 Maternity and Neonatal Services Reports** 10.1. Maternity and Neonatal Services Q2 Update 10.2. Maternity Incentive Scheme (MIS) Year 7 Update *Purpose: To **note** the Maternity and Neonatal Services Reports*	Report	S O'Brien *(15 mins)*
12.15	11.	**TB25/091 Digital Strategy Update** *Purpose: To **note** the Digital Strategy Update*	Report	M Gandy *(15 mins)*
12.30	12.	**TB25/092 Trust Board Meeting Arrangements 2026/27** *Purpose: To **approve** the Trust Board Meeting Arrangements for 2026/27*	Report	N Bunce *(5 mins)*
12.35	13.	**TB25/093 Research and Development Annual Report and Capability Statement** 13.1. Research and Development Annual Report 2024/25 13.2. MWL Research and Capability Statement *Purpose: To note the 2024/25 Research and Development Annual Report and to **approve** the MWL Research and Capability Statement*	Report	S Dowson *(15 mins)*

12.50	14.	**TB25/094 NHS Oversight Framework – Provider Capability Statement Self-Assessment** *Purpose: To **note** the Provider Capability Self-Assessment*	Report	R Cooper *(10 mins)*
Concluding Business				
13.00	15.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
13.10	16.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 28 January 2026 at 10:00		**13.15 close**
15 minutes lunch break				

Chair: Steve Rumbelow

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	26 November 2025
Agenda Item	**TB25/000**			
Report Title	Patient Empowerment Matters: David's Story			
Executive Lead	Sarah O'Brien, Chief Nursing officer			
Presenting Officer	Yvonne Mahambrey, Quality Matron Patient Experience Victoria Kilshaw, Unit Manager, Lilac Centre			
Action Required		**To Approve**	**X**	**To Note**

Purpose

To present Davids's experience of cancer treatment at the Lilac Centre at St Helens Hospital and how the products used have improved his experience and personalisation of care/ treatment.

Executive Summary

David is a 66-year-old gentleman, he retired in November 2024 and was diagnosed with bowel cancer in April 2025 after a routine blood test at his GP. David has been receiving care from the Lilac Centre for six months. The Lilac Centre is a day-case centre treating patients with haematology and oncology conditions.

Being told he would need chemotherapy, was overwhelming - not just the diagnosis, but the decisions ahead. One of the things that surprised David was that he had a say in which type of invasive line would be used to deliver his treatment. The idea of having something inserted into his body was scary, but being given a choice made him feel more in control. To others, it might just be a small device under the skin, but for David, it was hope. Hope that he could still hug his loved ones without fear and live his life even while fighting this battle. That choice reminded David that he mattered - that his voice mattered.

David was able to meet with the Procurement Matron as part of sharing his story and said that he now realises that they work quietly to make sure the best, safest, and most suitable options are available - not just based on cost, but on what truly matters to patients like him. David also spoke very highly about the Lilac Centre, including comfortable chairs (in which he has his treatment) the tasty meals that he is provided and free parking, especially as his pension is his only source of income. David spoke highly about the staff at the Lilac Centre, particularly their skill and ability to put him at ease and is grateful for the choices he continues to be offered about his care and that the care is delivered from knowledgeable, kind and caring staff, making one of the scariest and challenging times of his life as positive as it could be.

Lessons Learned:

- Patient Empowerment Matters: Giving patients a genuine choice, even in highly clinical decisions like the type of invasive line, can restore a sense of control and dignity during an otherwise overwhelming experience.
- Holistic Care Includes Family: Recognizing the emotional impact on families and involving them in the conversation supports the patient's wellbeing and strengthens the support system around them.
- Transparent Communication Builds Trust: Clear, compassionate explanations about options and the reasoning behind them help patients and families make informed decisions and reduce anxiety.

- Values-Based Procurement is Crucial: Procurement decisions that prioritise patient safety, quality of life, and emotional wellbeing over purely cost-driven factors enable better health outcomes and patient satisfaction.
- The creation of this story has reinforced to the Lilac centre team why they do what they do, and the real value felt by patients on the receiving end of their care

Next Steps:

- Integrate Values-Based Procurement: Formalise procurement policies that embed patient values and quality-of-life criteria alongside cost and efficiency considerations.
- Increase Visibility of Procurement Role: Educate clinical and administrative staff, as well as patients and families, about the important role procurement teams play in enabling high-quality, patient-centred care.
- NHS Supply Chain is keen to make patient stories a regular feature in their meetings and at board level. They have asked if they can share MWLs patient story to help highlight the real impact on care that procurement can have on patients.

Financial Implications
None as a direct result of this paper.

Quality and/or Equality Impact
Not applicable

Recommendations
The Board is asked to note the Patient Story.

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

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 29 October 2025
(Approved at Trust Board on Wednesday 26 November 2025)

Name	Initials	Title
Steve Rumbelow	SR	Chair
Gill Brown	GB	Non-Executive Director and Deputy Chair
Rob Cooper	RC	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
Ash Bassi	AB	Acting Chief Medical Officer
Nicola Bunce	NB	Director of Corporate Services
Steve Connor	SC	Non-Executive Director
Claudette Elliott	CE	Non-Executive Director
Neil Fletcher	NF	Associate Non-Executive Director
Malcolm Gandy	MG	Director of Informatics
Lisa Knight	LK	Non-Executive Director
Gareth Lawrence	GL	Chief Finance Officer
Lesley Neary	LN	Chief Operating Officer
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Chief People Officer

In Attendance

Name	Initials	Title
Jan Chillery	JC	Observer via MS Teams
Elsie Hayford	EH	Non-Executive Director Insight Programme Candidate (Observer via MS Teams)
Anuj Sharma	ASh	Account Director, Transformation Services, Ergea Group (Observer via MS Teams)
Dr Anya Sheltawy	AS	ST7 Anaesthetic Trainee, Mersey Deanery, Countess of Chester Hospital NHS Foundation Trust (Observer via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager
Marie Wright	MW	Halton Council Representative (Stakeholder Representative) (via MS Teams)

Apologies

Name	Initials	Title
Sarah O'Brien	SO	Chief Nursing Officer

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for October 2025 was Colette Hunt; HR Business Partner Medical Workforce and the Board watched the film of Malise Szpakowska reading the citation and presenting the award to Colette. **RESOLVED:** The Board **noted** the Employee of the Month for October 2025 and congratulated the winner
2.	**Chair's Welcome and Note of Apologies**
	2.1. SR welcomed all to the meeting and in particular JC, ASh and AS who were attending the meeting as observers. Additionally, SR welcomed AB to the meeting in his role as Acting Chief Medical Director (CMO). 2.2. SR also welcomed EH and noted that the Trust was taking part in the Non-Executive Director Insight Programme and EH would be on placement with MWL. This programme provided an opportunity for people interested in becoming a NED to shadow an NHS Board. 2.3. SR acknowledged the following awards and recognition for Trust staff and services: 2.3.1. Paediatric Dietician, Jennie Brown, had received an Ibex Honour from the British Diabetic Association. Jennie was recognised for her leadership in improving dietetic care for children with diabetes and for encouraging colleagues to enhance their clinical practice as dietetic supplementary prescribers. 2.3.2. Our recently retired hospital therapy dog, One Eyed Jack, was crowned the winner of the 'Animal Award' at the BBC Radio Merseyside Make a Difference Awards on 25 September. This award was given to an animal that improves the life of an individual or group of people, which Jack had done at Southport Hospital for seven years. 2.3.3. The Trust's Research and Paediatric teams had played a key role in the national 'HARMONIE' study which led to the rollout of a new RSV vaccine to protect premature babies. The team, led by Dr Rosaline Garr as Principal Investigator and supported by Research Nurse, Kerri Bowness, and the wider team, had contributed valuable data to this important study. The vaccine was now recommended in the UK's Green Book and offered to at risk infants born before 32 weeks. 2.3.4. Caroline Flynn, Macmillan Cancer Information and Support Service Manager, had recently secured funding to establish a West Lancashire Macmillan Cancer Information Centre. The centre, which was due to open early in 2026, will be based at the Concourse Shopping Centre in Skelmersdale and provide a comfortable space in which patients, carers

	and family members can ask questions about cancer and find support. This achievement means the Macmillan Cancer Information service can reach even more people across the MWL footprint. 2.3.5. Dr Ravish Katira, Consultant Cardiologist, recently published a book about the management of coronary heart disease as a resource for medical students and resident doctors. Apologies for absence were **noted** as detailed above
3.	**Declaration of Interests**
	3.1. There were no new declarations of interests made in relation to the agenda items.
4.	**TB25/074 Minutes of the previous meeting**
	4.1. The meeting reviewed the minutes of the meeting held on 24 September 2025 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the meeting held on 24 September 2025
5.	**TB25/075 Matters Arising and Action Logs**
	5.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 5.2. The following actions were closed: 5.2.1. Action Log number 13 (TB25/058 Board Assurance Framework) – BAF 1 has been updated to read 'Response to NW Clinical Senate Report and JOSG. **Action closed** 5.2.2. Action Log number 14 (TB25/059 Aggregated Incidents, Complains and Claims Report (Q1) – an update was to be provided under Agenda Item 10 (TB25/080 Aggregated Incidents, Complaints and Claims Report (Q2). **Action closed** 5.2.3. Action Log number 18 (TB25/067 Integrated Performance Report / Operational Indicators) - an update was to be provided under Agenda Item 6 (TB25/076 / 6.2 Operational Indicators). **Action closed** 5.2.4. Action Log number 19 (TB25/067 Integrated Performance Report / Operational Indicators) - SO advised that there had been no complaints received regarding cancer wait times in the preceding 12 months. **Action closed.** 5.2.5. Action Log number 20 (TB25/068 Committee Assurance Reports, 8.4 Strategic People Committee) - the Allied Health Professionals (AHP) vacancy rate, which had previously risen, has now fallen back below target in September. The most significant gaps were identified in Occupational Therapists (OTs), Operating Department Practitioners (ODPs), Physiotherapists, and Radiographers. Recruitment pipelines were in place to address the gaps, with the following expected by December:

	• OTs: 7.12 WTE • ODPs: 12.8 WTE + 2 WTE apprentices • Physiotherapists: 16.35 WTE • Radiographers: 4 WTE Further monitoring will continue to ensure progress is sustained. **Action closed.** 5.2.6. Action Log number 22 (TB25/073 2025/26 Winter Plan) - the QIA had been undertaken and received Executive approval. The Winter Plan was submitted by the NHSE deadline. **Action closed.** **RESOLVED:** The Board **approved** the action log
Performance Reports	
6.	**TB25/076 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for September 2025 was presented.
6.1.	**Quality Indicators**
	6.1.1. AB presented the Quality Indicators and highlighted the following: • The latest reported Hospital Standardised Mortality Ratio (HSMR) included data up to May 2025. The in-month figure was 86.8 (year to date (YTD) figure 90.4) which was below the target of 100. • The had been a national problem with the reporting of the Standard Hospital Mortality Indicator (SHMI) data, and this was being investigated with the supplier. Therefore, the metric had not been updated this month. • The inpatient Friends and Family Test (FFT) recommendation rate was 93.6% (internal target 90% and YTD position 95%). The 2024 national inpatient survey results had been published and a local action plan developed, which had been reported via the Quality Committee. • Clostridium difficile infection: There were six hospital onset-healthcare associated acquired (HOHA) and two community onset-healthcare associated (COHA) cases at MWL in September, a reduction compared to August. There had been 58 healthcare-associated cases YTD, and the Trust was above NHSE threshold by ten cases. In the most recent comparative regional UKHSA data available, Q1 benchmarking data indicates that MWL was below the C&M rate. • There had been 12 Escherichia coli (Ecoli) healthcare-associated cases reported in September (four HOHA and eight COHA). 82 healthcare-associated cases had been reported YTD which was seven cases above the NHS England (NHSE) threshold. • One hospital acquired pressure ulcer with lapses in care had been reported and this had been validated by the Harm Free Care Panel. • The rate of patient falls resulting in harm across all Trust sites was 0.19 per 1,000 bed days in September 2025. The Trust has recruited two

	additional Falls nurses to increase training and process improvement support. • One never event (wrong site nerve block administered in theatre) was reported in September and a Patient Safety Incident Investigation (PSII) was being undertaken, with early learning identified and initial actions implemented. • Complaints response within 60 days improved to 68.4% in September (target 80%). There had been an increase in the number of Stage 1 complaints received, mainly on the Whiston site. Work continued to address the backlog of complaints.
6.2.	**Operational Indicators**
	6.2.1. LN presented the operational indicators. 6.2.2. LN highlighted the following: <u>Urgent and Emergency Activity</u> 6.2.3. The 4-hour mapped performance for MWL in September was 78.4% (2025/26 target 78%). This compared to 75% nationally and 72.5% for C&M. 6.2.4. The proportion of 12-hour waits in the Emergency Department (ED) was 18.2% in September (18.3% in C&M). The target was to reduce to 10% by March 2026. 6.2.5. In September 90.6% of ambulances were handed over within 45 minutes. Southport Hospital was the best site across C&M and Whiston Hospital the most improved site. 6.2.6. Bed occupancy was 104.4% in September which equated to an additional 80.4 patients. This had a significant impact on patient flow and patients had needed to be bedded on corridors and in the escalation areas. 6.2.7. The percentage of patients with no criteria to reside (NCTR) had increased to 23.4% in September which was the highest level in several months. NCTR at Whiston, St Helens and Newton Hospitals was 20% and 27% at the Southport and Ormskirk sites. There had been several infection, prevention and control (IPC) issues at Southport Hospital which had impacted discharges mainly for the cohort of patients who needed to return to residential care homes. 6.2.8. LN provided feedback in respect of action log number 18 and clarified that the reported length of stay (LoS) figures included patients classified as NCTR and ready for discharge. The total non-elective length of stay including the NCTR patients was 3.9 days, however, if the NCTR patients were removed this reduced to 3.2 days. If this was calculated to exclude the zero day LoS patients there was a bigger variation from 8.1 days to 6.6 days. The Urgent and Emergency Care (UEC) Improvement plan continued to focus on the admission avoidance, in-hospital LoS reduction and discharge workstreams. 6.2.9. GL asked what the LoS difference would mean for available beds and LN confirmed this would equate to circa 200 beds, which was the number of medical beds at Southport Hospital.

6.2.10. CS reflected on the recent media report about the long waits in ED and commented that, whilst it had been a balanced piece of reporting, the impact of NCTR had not been mentioned. LN responded that the NHSE perception was that discharging patients was within a hospital's gift and the focus of improvement should be on reducing long waits in the ED. MWL had already enacted many of these actions as evidenced by the reductions in LoS, and the improvement in ambulance handover times. RC commented that the recent media piece had been undertaken as part of the winter campaign to increase awareness of what could be done to support the discharge process. RC acknowledged that if trusts were efficient at discharging the straightforward patients, this would help counteract the impact of the more complex discharges that took longer to arrange, however, the reality for MWL was that a third of the bed base was still being occupied by patients who would be better suited receiving care away from the hospital setting. As part of the Shaping Care Together (SCT) Programme, it had been highlighted that between 60% and 70% of patients attending ED could potentially access care through other services, particularly older, frail people as well as those needing support from a social services perspective.

6.2.11. SR commented that whilst the media had covered the discharge process, it was frequently reduced in public discourse to 'bed blocking'. However, the reality was far more complex. SR reflected on the efforts that were undertaken within the hospital to ensure that patients who could be discharged and did not require social support from the local authority were able to leave hospital promptly, when they were medically fit to do so. AB commented that prolonged hospital stays led to increased deconditioning of patients, a point that was not always adequately conveyed in media coverage. The overarching message was that individuals generally fared better in their own environments, and that alternatives to hospital admission/hospital stays produced better outcomes for this type of patient.

Elective Recovery:

6.2.12. The 18 week Referral to Treatment (RTT) performance was 64.2% in September 2025 against the target of 63.7% for 2025/26.

6.2.13. Performance against the 52-week waiting target (less than 1% of patients waiting over 52 weeks) was 2.3% in September.

6.2.14. At the end of September, there had been 55 patients waiting over 65 weeks, including two individuals awaiting shoulder surgery that required a product which had been recalled. This represented an improvement from 135 patients in August and 232 in July.

Diagnostics

6.2.15. Performance was 90.7% in September (target 95%). The main reason for underperformance remained Non-Obstetric Ultrasound (NOUS).

6.2.16. There was a focussed piece of work to improve productivity and optimise capacity.

Cancer Services

6.2.17. Performance against the 62 day cancer standard had improved to 82.5% (target 85%) in August. National performance was 69.1% and C&M performance was 76.2%.

6.2.18. Performance against the 28 day cancer standard had improved to 64.2% (target 77%) but remained challenged. Action was focussed on three tumour sites (skin, lower gastrointestinal (GI) and breasts) working with the C&M Cancer Alliance.

6.2.19. LN observed that, due to the lag in cancer performance reporting, it was difficult to assess the impact of the actions that had been taken. To help monitor progress internally four proxy metrics had been established to help ensure the right actions were being taken. The impact of the improvement actions was expected to flow through to the national reporting from November.

6.2.20. Following the introduction of skin analytics using artificial intelligence (AI) the skin cancer wait had reduced from 8.2 days to 4.7 days.

6.2.21. The service had also gone live with autonomous practise. This reduced the need for the double check by an extra clinician and released clinicians to see more patients. Currently this service was only available for patients with one lesion but it was anticipated to go live from November with the plus one lesions. MWL was the first Trust to adopt this.

6.2.22. With regards to lower GI there was a consultant live triage in place and the percentage of patients who were sent straight to tests had increased from 38% to 49% and the average triage time had reduced from 7.7 days to 0.4 days.

6.2.23. GB asked what was being done to reduce the waiting lists and improve productivity for trauma and orthopaedics, general surgery and ophthalmology, which had the longest waits. GB suggested that if this was not reported to the F&P Committee an update should be provided to Board. LN confirmed that a report had recently been presented at F&P Committee and undertook to circulate the presentation to Board members.

Action:

- LN undertook to circulate the report that had been presented at F&P Committee to Board members

6.2.24. RC reflected on the 62-day cancer performance and the differences in performance between hospital sites. Overall performance was 82.5% but performance at Southport Hospital was 58.5%, while performance was 89.3% at St Helens Hospital and RC asked what was being done to standardise performance across MWL. LN explained that reviews were taking place of all the tumour site pathways, to identify the differences at each point. Initially the focus had been on the three most challenged tumour site pathways, with urology and gynae identified for phase 2.

6.3. RC noted that with the 62-day performance standard, breaches were recorded in the month a patient was actually treated. Therefore as treatment

	numbers increased as the backlog reduced, it was expected that the number of breaches recorded in the month would also rise. Consequently, a temporary dip in performance was to be anticipated during this process. LN agreed and reported that the actions taken had resulted in a significant reduction in the backlog from 280 patients, to less than 200 who had not had their diagnosis confirmed and commenced treatment. The focus remained on reducing this backlog and ensuring that patients were placed onto the appropriate pathway. 6.4. GB shared her recent experience of the Musculoskeletal health (MSK) service at Ormskirk Hospital following a self-referral. GB felt the services was doing all the things expected in the new NHS 10 year plan, namely digital referrals, a focus on prevention and provided close to where people lived. SR thanked GB for her feedback on the service and asked if there was anything she felt the service could have done better, to help them develop. GB reflected that it had been difficult to find the information about the service on the Trust's website and had she not known the service she would have found it difficult to refer herself. GB had already discussed this with the Consultant Physio Service Lead, Therapy Outpatients. RC commented that this was an example of a service that was provided at two of MWL's sites namely Southport and Ormskirk Hospitals but not at Whiston and St Helens Hospitals and noted that he had discussed the ambition to rollout this service across MWL with the Consultant Physio Service Lead. SR agreed that accessibility of community based services was a priority for the NHS going forward and it would be important to ensure that these services were easily accessible for all patients. GB acknowledged that not all individuals were digitally literate; however, the NHS app was intended to become the central access point for services such as this. MG reported that there were options to incorporate AI interactive tools to help patients navigate the Trust website and find the services they needed.
6.5.	**Workforce Indicators**
	6.5.1. MS presented the Workforce Indicators and highlighted the following: • The compliance rate for appraisals was 87.5% (target 85%) an increase from 74% in August. The appraisal window for 2025/26 had closed on 30 September 2025, however any outstanding appraisals would continue to be undertaken to ensure all staff had an annual appraisal. • The compliance rate for mandatory training had remained consistent at 89.4% (target 85%) and any teams or individuals with compliance below 85% were being performance managed by the Divisions. • Sickness absence had increased to 6.9% in September from 6.7% in August (target 5%). This was in line with the C&M and national trends. The top three reasons for sickness absence remained anxiety, stress and depression, which accounted for 37% of all absences, musculoskeletal health (MSK) (10%) and gastrointestinal issues (8%). The Absence Support Team were targeting the high sickness areas and there was a continued focus on the welcome back conversations. One

	of the themes from the Divisional Performance Reviews was the impact of short term sickness on service delivery. There were currently circa 130 members of staff with long term sickness absence who were being supported by the Absence Support Team. The Trust was working with colleagues across the Integrated Care Board (ICB) to review sickness absence management policies, with the objective of reducing sickness absence by 1%. The current draft policy differed significantly from the national guidance. • Over 1,500 staff members or 19% of the total front line workforce had received their flu vaccinations as part of the annual Flu Campaign. • In-month staff turnover had increased to 0.9% in September (target 1.1%). The rolling 12-month staff turnover remained stable at 10% (target 13%). 6.5.2. GB reflected on recent media reporting of BMA opposition to the standard agency and bank pay rates in C&M and asked if there were any updates on this. MS reported that the BMA had written to the ICB Chief Executive and NHSE Northwest Regional Director about the introduction of the standard rate card, which would be aligned to the rates already in place in Lancashire and South Cumbria and Greater Manchester. As a result a meeting had been scheduled for the BMA to meet with the ICB Medical Director and the NHSE Northwest Regional Medical Director. 6.5.3. SR reflected that controlling variable pay and reducing bank and agency use was a big theme in managing the financial pressures and recognised the challenges in balancing this with the need to maintain essential services. MS reported that the impact of such changes were being closely monitored by the Chief Medical Officers (CMOs) and Chief Nursing Officers (CNOs) across the ICB to ensure there was no detriment to patient safety or the quality of services. SR was assured that MWL had effective processes for escalating any safety concerns. 6.5.4. SR commended the 87.5% compliance rate for appraisals.
6.6.	**Financial Indicators**
	6.6.1. GL presented the financial indicators and reminded the Board that the Trust had set a deficit plan of £10.7m for 2025/26, however, this would have been a £41m deficit plan excluding £31m of national deficit support funding. The plan was underpinned by £35m of system led and strategic cost reduction opportunities and an internal Cost Improvement Programme (CIP) of 5%. 6.6.2. At month 6, the Trust was reporting an adjusted position of a £37.1m deficit excluding deficit support funding and was £3.7m ahead of plan. 6.6.3. GL highlighted the following: • Formal confirmation of the contract from the ICB remained outstanding.

- The Trust was below the levels of planned activity, however there was an action plan in place to recover this in the second half of the year.
- There remained a continued risk around the Southport Hospital Community Diagnostic Centre (CDC) funding and funding from Greater Manchester as well as Lancashire and South Cumbria ICBs .
- There had been an improvement (reduction) in agency spend and this was monitored weekly via the Finance Improvement Groups.
- The Trust had successfully delivered £24.2m of CIP YTD against a full year plan of £48.2m (£1.9m ahead of plan).
- The Trust's cash balance was £1.9m and the Trust had received cash support of £22m during September and October and further cash support had been requested for November.
- There had been a slight increase of £400,000 in aged debt and this continued to be monitored. It was noted that 75% of the aged debt related to NHS debt, however this also included NHS organisations that were not part of the NHS England.

6.6.4. GL reported that the capital forecasts for the current financial year had been reviewed and within the capital plans there were two elements that would not be drawn down this year. The first related to the Electronic Patient Records (EPR) system (in excess of £10m). The second related to the Southport Hospital CDC capital funding that had been allocated at the start of the financial year by the ICB. These allocations would be returned.

6.6.5. The F&P Committee had undertaken a detailed review of the financial forecast at month 6 including the risks and mitigations relating to delivery. The best case scenario was to deliver slightly above plan whilst the mid case scenario was below the target by £6.8m. This forecast had not included any significant increase in costs related to winter pressures or the proposed Resident Doctors industrial action and these factors would be closely monitored.

6.6.6. GB reflected on the cash position and asked if the £11m of cash support would need to be repaid. GL agreed that 0.7days of cash was a significant risk and if further cash support was not approved by NHSE, the cash preservation measures discussed with the Board earlier in the year, would need to be implemented, which included delaying payments. GL also clarified that there were two elements to the cash support, the first related to what the Trust actually needed in respect of its Public Dividend Capital (PDC) payments and did not have to be repaid. The second was due to the Trust not receiving the deficit support funding as part of the system financial intervention by NHSE and would need to be paid back once these funds were released.

6.6.7. GB asked if there would be an impact on aged debt. GL responded that most of the aged debt related to the Lead Employer (LE) but remained relatively small compared to turnover. Meetings had been scheduled with the regional team to discuss the impact to the Trust because of the LE

	element compared to other organisations and the need for different metrics to monitor this element. 6.6.8. CE acknowledged the hard work of everyone involved in the delivery of the CIP performance. 6.6.9. SC asked what the sentiment was among the other Chief Financial Officers (CFOs) in the region regarding the impact of cash constraints. GL responded that everyone was concerned as some organisations had received less cash support than requested and had to initiate their cash preservation plans. Another concern was that the cash was in the wrong place in the system and the establishment of a working group to review cash flow and how funds were moved around the system had been suggested. 6.6.10. SR noted that the CIP target in 2025/26 was higher than ever before and recognised the scale of the challenge, even with the Trust's established track record in achieving such targets. SR asked whether there had been an increase in late payments of the LE invoices. GL responded that this concern had been raised with NHSE nationally and regionally at the start of the year, who had subsequently advised trusts of the requirement to make LE payments on time, and so far, there had been no late payments and several organisations had actually paid in advance. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**TB25/077 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. RC presented the Executive Committee Assurance report for the meetings held in September 2025. Bank or agency staff requests that breached the NHSE cost thresholds were reviewed at each meeting, and the Chief Executive's authorisation recorded. Reports from the weekly vacancy control panel were presented at every meeting. 7.1.2. RC highlighted the following items from the report: • The Committee had reviewed proposals to optimise beds at Southport Hospital and release a ward to allow for refurbishment. Ward refurbishment work had been completed on Ward D at Ormskirk Hospital. This refurbishment provided an opportunity to create additional capacity as part of the winter plan. • The Committee had approved the Core Clinical Skills Training Needs Analysis (TNA) proposal.

- The Committee had noted the national changes to the Friends and Family Test (FFT) and the way forward for the Trust as well as C&M had been discussed.
- The Committee had received the National Inpatient Survey results and action plan and the Maternity Patient Experience Survey action plan, which had been reviewed to assure that the proposed actions would impact the areas where the survey responses had highlighted areas for improvement.
- The Committee had approved the Medical Workforce Principles which supported the general workforce principles that had been developed earlier in the year.
- The Committee had reviewed the final version of the Winter Plan and Board Assurance Statements which had then been submitted.
- The Committee had approved the revised Mental Health Framework which set out how the Trust could support patients with mental health needs, if they needed to receive inpatient care.
- The Committee had approved the Ambient Voice Technology (AVT) pilot which would assist clinicians by improving communication with GPs and patients and reduce the requirement for typing of clinical letters. The use of AVT was being supported nationally and regionally.

7.1.3. SC noted the substantial number of Freedom of Information (FOI) requests received between April and June and asked whether the volume of requests had affected response times and if there were any discernible trends in the requests. RC responded that all NHS Bodies received high volumes of FOI requests. The 365 FOI requests to MWL had generated approximately 3,000 individual questions, which was an increase in the number of questions per request. The Trust, continued to ensure that all appropriate information was made public via the publication scheme, there was also a library of previous FOI responses that requesters were directed to if they covered the same information. MG noted that FOI requests originated from a variety of sources, including the media, commercial organisations, and individuals seeking information regarding the organisations performance or data held and responding to these requests often necessitated collaboration across several different teams. The adoption of technology solutions, including Microsoft Copilot, was also being considered to facilitate and expedite response processes. SC queried whether failing to respond within the prescribed timeframe resulted in any consequences. MG confirmed that responding within 20 days was a statutory requirement, and although the Information Commissioner's Office (ICO) recognised the increasing volume and complexity of requests, would not accept exceeding the 20-day deadline as standard practice. The Trust endeavoured to demonstrate that all reasonable measures were being taken to ensure timely responses.

7.1.4. GB asked if the AVT technology could be used to generate meeting minutes. NB confirmed that this was already being trialled. MG advised that the initial deployment of AVT technology was planned for clinical

	settings, with potential expansion to multi-disciplinary team (MDT) meetings and other correspondence and would always be subject to appropriate oversight and quality assurance procedures. 7.1.5. GB referred to an article from MIAA concerning the governance of technology usage and enquired whether the Trust had adhered to the appropriate governance procedures. RC assured that the Trust remained compliant, noting that documents, such as patient communications or meeting minutes, were subject to quality checks for accuracy. MG reported that a draft AI Policy had been developed and was scheduled for presentation to the Executive Committee. This policy had been aligned with national guidance and placed emphasis on quality assurance, especially in communications with patients. It had been agreed that all outputs generated by technology, including letters, would always undergo human quality assurance prior to distribution. The remainder of the report was **noted.**
7.2.	**Quality Committee**
	7.2.1. CE presented the Quality Committee Assurance Report for the meeting held on 21 October 2025 and noted that several items were to be discussed in reports later in the Board agenda and would therefore not be covered in this report. 7.2.2. Other items to highlight from the report were: • There had been an increase in the number of complaints received compared to Q1 and whilst there had been an improvement in response times this was still below target. Members of the Patient Advise and Liaison Service (PALs) team were spending time in the EDs to help resolve patient concerns informally, wherever possible. • The increase in the number of Covid 19 /flu and norovirus cases had impacted on patient flow and the IPC team were supporting the EDs and clinical teams as well as promoting the correct Personal Protective Equipment (PPE) use, timely samples, FIT testing, and the appropriate allocation of side rooms. • The Committee had received the Patient Safety Council Assurance Report and noted that no new PSIIs had been commissioned. • The Committee had received the Safeguarding Report for Q2 and had discussed the Ferrara case law in relation to the Deprivation of Liberty Safeguards (DoLS) which was being reviewed nationally. A national consultation was in progress regarding the proposed introduction of Liberty Protection Safeguards (LPS) as a replacement for DoLS. The situation would be monitored, as any changes would necessitate an assessment of the impact on vulnerable patients and the responsibilities of the Safeguarding teams. • The Committee had noted that overall compliance with safeguarding training had been maintained at a high standard. However, Level 3

	Adult Safeguarding training remained an exception and the Committee had been assured that appropriate plans were in place to address this. The remainder of the report was **noted**.
7.3.	**Strategic People Committee**
	7.3.1. CS, on behalf of LK, presented the Strategic People Committee (SPC) Assurance report for the meeting held on 22 October 2025 and noted that some key issues had already been discussed in earlier reports to the Board and would not be repeated. 7.3.2. CS highlighted the following: • Achievement of the annual appraisal compliance target had been acknowledged. • Time to Hire remained a challenge and ongoing actions had been reported, including the implementation of a new Occupational Health system. However, this metric remained resistant to quantifiable improvement, despite the considerable efforts to address it and several further enhancements had been identified. The did not attend (DNA) rate for health and well-being appointments had improved (reduced) and reflected the team's increased communications and promotion of the benefits. • The Committee had noted the results of the LE stakeholder survey which had reflected the team's commitment to continuous improvement, actively seeking feedback from resident doctors and doctors in training to inform enhancements. Certain improvements were outside of the team's direct control, but the report demonstrated how they worked with other organisations to influence change. • The Committee had approved the establishment of an Equality, Diversity and Inclusion (EDI) Council, to support EDI governance which in turn would be supported by three steering groups, the Disability Steering Group, LGBTQIA+ Steering Group and the Race Steering Group. • The Committee had acknowledged the assurance on delivery of the PricewaterhouseCoopers International Limited (PWC) "Grip and Control" recommendations that needed to flow through both the SPC and F&P committees because of the nature of the recommendations. A single assurance report was being developed, where the committees could focus on the specific elements. SR commented that this demonstrated the whole organisational response to improving the financial control. 7.3.3. LK expressed satisfaction with the progress made in reducing the DNA rates for Health, Work and Wellbeing appointments and acknowledged the considerable effort invested in this. MS commented that some of the anticipated outcomes following the introduction of the new OPAS system, had now materialised and were delivering tangible benefits. The

	effectiveness of staff reminders, similar to those used for patients, had been recognised. The remainder of the report was **noted**.
7.4.	**Finance and Performance Committee**
	7.4.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 23 October 2025. The Committee had reviewed the Finance and Performance CPR and monthly finance report, but the key points had already been discussed in earlier reports on the Board agenda so would not be repeated. 7.4.2. CS reported that both RC, LN and GL were unable to attend the meeting, and the Committee recognised the ongoing expectation to attend both ICB and NHSE meetings, despite the impact on the Trust's corporate governance. 7.4.3. CS noted that there had been developments in the week between the meeting pack being distributed and the meeting itself which impacted several of the reports which were discussed as part of the emerging narrative. There was a prevailing sense of change, particularly regarding methods of working, payment systems, and allocation systems, which were under national discussion. However, there has been no clarity or guidance regarding the specific application of these changes to be able to model their impact locally. 7.4.4. The Committee had been assured that a comprehensive overview of these ongoing developments had been provided. 7.4.5. Other points to highlight from the report were: • The "Grip and Control" report was received from PwC and further actions given the current financial climate had been suggested, although it had been noted the Trust had previously implemented many of the actions, following a similar review in 2024/25. The Committee had noted the increased pressure on the finance team and across the Trust in external reporting. It had also been recognised that the planned internal savings were being delivered but planned efficiencies were not being realised in other areas, including the ICB schemes. • The Committee had received the Corporate Benchmarking report which was a national exercise and provided a comprehensive overview of the Trust's costs. The report indicated that the Trust was currently positioned within the lower quartile on the national scale. The Committee acknowledged the ongoing challenge of achieving upper quartile quality outcomes while operating with lower quartile cost levels, recognising the inherent difficulty in striving for significant improvement from a comparatively lower baseline. • The Committee received the Elective Care Performance Review, which provided details of the specialities with the longest waiting times, and

	their recovery trajectories. The Committee had asked for more assurance that the lessons learnt from past performance patterns had been incorporated into the current plans, to give confidence of success. 7.4.6. GL commented on the complexity of modelling the Trust's underlying financial position and future plans, without having the national assumptions and payment mechanisms clarified. Additional guidance had been issued the day after the Committee, and these were being worked through to understand the impact on the three to five year financial modelling. GL commented that he understood that this presented a challenge in keeping all Board members appraised and sighted on the issues and recognised the importance of all Directors having clarity. However the intention of the three year planning frameworks was to create more stability and certainty for medium term planning, which was to be welcomed. 7.4.7. SR commented that it was important to acknowledge the amount of additional work involved for the Finance team and others across the Trust because of the different interventions and additional reporting requirements. SR reported that there had been a commitment from NHSE Northwest, the ICB and PwC to try and coordinate and streamline their requests, this, however, there did not appear to have been any improvements, to date. 7.4.8. The Committee had received Council Assurance Reports from the Procurement Council, CIP Council, Capital Planning Council, Estates & Facilities Management Council, and IM&T Council, with no issues escalated. The remainder of the report was **noted**. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
8.	**TB25/078 Corporate Risk Register**
	8.1. NB presented the quarterly Corporate Risk Register (CRR) report which provided an overview of the risks that had been escalated to the CRR via the Trust's risk management systems. 8.2. NB reminded the Board that a single Risk Management Framework (RMF) had been in place since the amalgamation of the two former trusts. However, this was only the second quarterly report since the introduction of InPhase, the single risk and incident management system, in March 2025. 8.3. Following the implementation and embedding of the single system there was now an opportunity to review the RMF to ensure more standardisation,

	particularly in respect of scoring and the description of risks. This work was being undertaken and it was expected the new RMF would be in place for 2026. 8.4. The current report was drawn from InPhase on 01 October and reflected a snapshot of the risk position at the end of September. 8.5. NB reported that the total number of risks on the risk register was 994 compared to 992 in July 2025 (the last quarterly report to Board). The following was highlighted: 8.5.1. 23 Risks were escalated to the CRR compared to 24 in July. 8.5.2. Four new escalated risks were reported on the CRR compared to July. 8.5.3. Five risks had been closed or de-escalated from the CRR since July. 8.6. NF reflected on the improved report which was easier to read and commented that there were several 'past due' review dates and asked whether these had been reviewed since the snapshot was taken. NB agreed that the number of overdue for review risks was a concern that had been highlighted at the Risk Management Council and escalated to the Executive Committee. Although the number of overdue risks did tend to be seasonal, the current position was unacceptable. There would always be some overdue risks, as this was a live system, but the current levels were a concern. Additional scrutiny of overdue risks had been requested, including the escalation of any risk which had missed more than one review cycle, and additional training and support was being provided to support the divisional teams to address this issue. 8.7. NF commented that Risk number 2 (Pharmacy robot) had been discussed at the F&P Committee, however, Risk number 20 (the obsolete Whiston Hospital Decontamination Unit FC4 Washer Disinfectors), which would have a direct impact on patient care, had not been discussed and asked if this was a new risk. NB responded that the pharmacy robot was included on the Capital Programme for replacement during 2025/26 and the new robot was currently on order. The decontamination units at both Whiston and Southport Hospitals were reaching their end of life and an option appraisal for Whiston site, had been completed. A similar exercise for Southport site had been requested, and these would then inform equipment bids for the 2026/27 capital programme. This was the agreed process for prioritising requests and was always oversubscribed for the available capital resource. 8.8. SC agreed with NF's comments regarding the improved report and reflected on Risk 20 (**If** the Trust experiences increased demand and bed occupancy above planned capacity, **then** there will be reduced patient flow) and observed that this remained a significant risk with a score of 20 despite the various initiatives and interventions. NB responded that this was a broad risk covering various issues around corridor care, patient experience and patient flow which remained one of the key challenges for the organisation and indeed the wider system. SC asked how the scoring of the risk was agreed,

	and NB confirmed that any risk escalated to the CRR was reviewed and approved by the lead Director for that area. Guidance was included in the RMF and in InPhase, based on the standard NHS risk scoring matrix, to encourage a standardised approach to scoring, but inevitably perceptions did sometimes influence the initial scoring. 8.9. GB referred to Risk 17 (**If** Commissioners do not honour the revenue funding for the Southport Community Diagnostic Centre, **then** the Trust will have an increased financial pressure) and asked if this meant the CDC might be decommissioned if the funding could not be agreed. GL responded that discussions with Commissioners were ongoing, noting that the Southport CDC had been part of wave one bids and the national team had subsequently established a set of parameters for CDCs which they now wanted to retrospectively apply to Southport. Discussions were focused on whether alternative configurations, such as a different CDC model or site, should be considered. However, the current facilities provided the right level of capacity for the population and introducing more capacity was unnecessary. From a productivity and value for money perspective, the current CDC was the optimal configuration given the circumstances at Southport. 8.10. NF asked if risks 5 (**If** patients have duplicate hospital numbers, **then** there is a risk of causing patient harm) and 23 (**If** there are data quality errors and patient number mismatches due to legacy IT systems, **then** there is a risk of patient harm) were the same issue and should be merged. MG agreed to review if there should be an overarching CRR risk, however, did confirm these were different risks. **Action:** MG to review risks 5 and 23 to determine if they could be combined into a single CRR risk. **RESOLVED:** The Board **noted** the Corporate Risk Register
9.	**TB25/079 Board Assurance Framework**
	9.1. NB presented the Board Assurance Framework (BAF) and noted that each BAF risk has been reviewed by the lead Executive and updates provided in relation to closed and new actions. 9.2. NB highlighted that BAF 2 (Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners) had some overdue actions which related to the outstanding contract negotiations. 9.3. There had been a discussion at Executive Committee around lowering the risk score for BAF 3 (Sustained failure to maintain operational performance/deliver contracts) as most of the operational standards were being achieved for the year, however, it had been proposed that this review be deferred to January, to ensure performance was maintained during winter.

	9.4. There were several actions with revised completion dates and the Executive Committee had recognised that this was not ideal and would be addressed for future updates. **RESOLVED:** The Board **approved** the changes to the Board Assurance Framework.
10.	**TB25/080 Aggregated Incidents, Complaints and Claims Report (Q2)**
	10.1. AB, on behalf of SO, presented the Aggregated Incidents, Complaints and Claims Report for Q2 of 2025/26. 10.2. AB highlighted the following: 10.2.1. There had been 7,713 incidents reported across MWL in Q2. 10.2.2. Of these 5,679 were patient safety incidents and 56 were graded as moderate harm or above. All the incidents graded as moderate harm or above were reviewed by the Executive Led Patient Safety Panel. 10.2.3. The highest number of incidents reported related to: • Pressure Ulcers, including those not acquired under Trust care, were the highest category (901). 79% of these were community acquired, and 21% hospital acquired, which was consistent with Q1 • Accidents including slips, trips, falls, and collisions were the second highest number of reported incidents in Q2 (851). The Falls Nurses were focused on reducing the number of falls resulting in harm. • Duty of Candour had been completed for all incidents that met the threshold. 10.2.4. There were 161 new first stage complaints in Q2 and delays in clinical treatment remained the main reason for complaints. 10.2.5. There were 1,232 Patient Advise and Liaison Service (PALS) contacts in Q2 (excluding Ask Rob enquiries and compliments). 10.2.6. 24 new clinical negligence claims were received in Q2. 10.2.7. 27 new inquest notifications had been received, and 28 inquests had been closed. 10.2.8. No Prevention of Future Deaths notices (PFDs) had been issued during the period. 10.3. AB provided an update in respect of Action Log number 18 and reported that a review of the general surgery claims had been completed. The review had looked at 28 claims and liability had been admitted in 12 (42%). Of the remainder, 57% had been successfully defended. Failure of treatment was the main category of the claims, however, there had been no common themes or connections between these claims. In each case learning had been shared across the Division and wider Trust if applicable. 10.4. CS asked if the Trust had any information on how individuals, families, and patients perceived the complaints management process as it was important

	to ensure that the approach to dealing with complaints was acceptable to all involved. NB advised that a questionnaire asking for feedback on the process was sent to all complainants once the process was completed, although the return rate had tended to be quite low. The feedback had been used to review and improve the process. 10.5. CE reflected on the discussion at the Quality Committee around pressure ulcers and commented that the reported 79% incidence of community acquired pressure ulcers appeared to be high and asked if this required further investigation to better understand where the cases were occurring as well as the underlying factors contributing to this. AB responded that SO was already looking into this and he would ask her to present an update at a future Quality Committee meeting. **Action** SO to provide an update on the high rate of community acquired pressure ulcers at a future Quality Committee. 10.6. AMS reported that there had been a discussion at Executive Committee around the Community services and lack of standard key performance indicators (KPIs) for these services nationally. 10.7. NB clarified that the definition of 'community acquired' was used to distinguish these pressure ulcers from 'hospital acquired' and did not necessarily mean that they had been acquired within the Trust's community services. 10.8. GB commented that following previous discussions there had been assurance that there was a good system in place for regular interactions between the Trust's hospital and community teams and also feedback and support to care homes. 10.9. NF reflected on the Incidents Reported graph which had initially indicated a decrease in reported incidents in Q3 of 2023/24 and then an increase in Q2 of 2025/26 and asked whether all incidents were being reported, particularly in Q3 of 2023/24 when compared to Q2 of 2025/26. NB noted these variations pre-dated the introduction of InPhase so were not linked to the introduction of the new system, although this may have accounted for supressed reporting in Q1 of 2025/26. AB noted there had been seasonal trends over many years but the introduction of the Patient Safety Incident Response Framework (PSIRF) and the embedding of the 'no blame' culture were designed to encourage the reporting of incidents. **RESOLVED:** The Board **noted** the Aggregated Incidents, Complaints and Claims Report (Q2)
11.	**TB25/081 Learning from Deaths Quarterly Report (Q4 2024/25 and Q1 2025/26)**

	11.1. AB presented the Learning from Deaths Quarterly Report covering Q4 2024/25 and Q1 2025/26 which provided an overview of the mortality reviews which had taken place to provide assurance that deaths occurring in hospital undergo a robust review to identify any lessons that can be learnt. AB commented that due to the gaps within the Learning from Deaths teams the report was not as comprehensive as previous ones, however a new Learning from Deaths Lead had now been appointed and additional mortality reviewers had been recruited to complete the Structured Judgement Reviews (SJR). 11.2. AB highlighted the following: 11.2.1. There were currently 52 outstanding SJRs for Q4 and 29 for Q1 at Whiston and St Helens Hospitals. Additionally there were 58 historical SJRs overdue for review dating back to Q1 2024/25. There had been one case graded as amber in Q4. 11.2.2. The switch to the new InPhase reporting system had initially delayed the identification of cases that needed to be referred for an SJR at the Southport and Ormskirk Hospital sites, however a workaround was now in place and retrospective reviews were being undertaken. 11.2.3. Any key learning points from the SJRs continued to be distributed across the organisation. *(GB took over as Chair briefly as SR had to step out of the meeting)* 11.3. In response to a query from MG, AB explained that there had been some complication transferring the legacy SJR referral data from the old Southport and Ormskirk Datix system to the new integrated InPhase risk and incident management system, however this had now been resolved. 11.4. CS asked how the learning was shared across the organisation and if issues such as hypoglycaemia in non-diabetic patients could be incorporated as reminders into the digital patients record as well as the high volume of other communications and asked whether it would be possible for the key learning messages to be digitised into the system. AB commented that currently there was a reliance on key learning points being discussed in the clinical and governance meetings for dissemination, which was why only a small number of key messages were live at any time, so they could retain impact. RC confirmed that it was possible to place alerts in the EPR for specific patients or conditions/pathways as reminders to clinicians, and MG commented that this was an area of digital innovation and future development in healthcare. **RESOLVED:** The Board **noted** the Learning from Deaths Quarterly Report for Q4 2024/25 and Q1 2025/26
12.	**TB25/082 Workforce Reports**

12.1.	**Workforce Race Equality Standard Report (WRES) (including action plan)**
	12.1.1. MS presented the Workforce Race Equality Standard Report (WRES) for period ending 31 March 2025 and the action plan that had been developed as a result and noted that these were statutory reports that must be published. 12.1.2. MS highlighted the following: • There had been an increase in the number of Ethnic Minority staff within the workforce across all bands (from 15.1% in 2024 to 16.3% in 2025), with 50.5% of this in the Clinical and Medical and Dental roles. • Senior leadership remained an area of improvement. Board representation had been 5.6%. • The proportion of Ethnic Minority staff in clinical roles was significantly higher than the local population. • There had been an improvement from 1.61 in 2024 to 1.79 in 2025 in respect of appointments for Ethnic Minority candidates. Some of the actions had included the introduction of more diverse interview panels and the introduction of mandatory EDI training for all recruiters. These actions would continue. • In the 2024 staff survey Ethnic Minority staff reported experiencing higher levels of bullying and harassment from a patient, family member or members of the public, as well as a lower confidence in career progression compared to White staff, which reflected the national trends. This was a key area of focus in the action plans which included reporting mechanisms, zero tolerance and expansion of the Trust's career progression programmes for Ethnic Minority staff. The impact of these actions would be tracked through future staff survey results. • The action plan also proposed strengthening EDI governance with the establishment of an EDI Council which would be supported by three steering groups, for Disability, LGBTQIA+ and Race. 12.1.3. CE thanked MS for the comprehensive report and supported the continued focus on the core actions that were making a difference for staff. CE reflected on the recent Black History Month webinar that she had attended and the positive questions and observations from staff regarding the support within the organisation and the importance of maintaining an open dialogue with staff especially with the current societal challenges and changes in behaviours. CE felt it was important to acknowledge that for some ethnic minority staff, current events might be traumatic or reminiscent of past experiences in the UK. It had been beneficial for staff who attended the webinar to be able to discuss these issues. CE commended the Trust for its supportive approach and emphasised the importance of staff feeling able to raise and discuss concerns, with assurance that these would be listened to and addressed. MS thanked CE for her feedback and agreed that physical and psychological safety was a concern for ethnic minority staff and work was ongoing with the relevant teams regarding security and promoting a zero-tolerance approach.

12.1.4. MS reported that the Trust's senior leadership team would be briefed on the WRES data and asked for any further ideas to support the workforce that could be incorporated into the action plans.

12.1.5. SR was pleased that staff were better supported by employers than they had been in the past, which at MWL included the recently launched anti-racist strategy aimed at addressing anti-racist behaviour. RC agreed and noted that as the Trust's Senior Anti-Racism Champion, he had been pleased that the most recent launch event at Ormskirk hospital had been the best attended of the three launch events. Feedback from the launch events indicated that the taster sessions on cultural competence and active bystander training had been well received, and the full courses were fully booked. RC also commented that that individuals were now escalating concerns regarding inappropriate behaviour and that, by promoting the role of active bystanders, the organisation had encouraged staff and the wider community to intervene. The active bystander course equipped individuals with practical steps to address issues in a non-confrontational and non-aggressive manner. Attendance and enthusiasm for this training had been demonstrated during its delivery at the recent Freedom to Speak Up Champions Day. CE noted that the group attending the webinar had acknowledged that further work remained necessary within both NHS and wider care services.

12.1.6. CS asked for further information about the changes that had been made to recruitment practices. CS reflected that the NHS had historically adopted a rather inward-looking and conservative approach, particularly due to its professionally driven recruitment processes in both clinical and corporate services. Job descriptions and person specifications often insisted on extensive experience, which could limit the pool of potential candidates for senior positions. Maintaining a strong supply chain of talent was important, however, overly internal recruitment strategies might not reach a sufficiently broad audience. MS responded that the Trust very rarely only advertised the senior roles internally and, whilst the Trust was committed to developing internal talent and succession planning, the need for external recruitment to bring new skills into the organisation was also recognised. It was noted that there was ongoing work and collaboration with local colleges across diverse staff groups, with an aim to promote opportunities and attracting a wide range of candidates, however, these initiatives would require time before the benefits were fully realised.

12.1.7. MS reported that qualification-based barriers existed within NHS recruitment and acknowledged the ongoing requirement to ensure that relevant skills and experience, rather than length of service alone, informed recruitment decisions. Recent trends indicated a shift towards greater inclusion of individuals from outside the traditional NHS workforce, resulting in positive impacts through increased workforce diversity. One of the recent actions from the SPC was for MS and the Chief Medical Officer to undertake

	a review of medical leadership appointments, as 50% of the medical workforce had come from diverse backgrounds, but this was not reflected in senior leadership roles. Additionally, work continued to support international recruits, particularly nurses, and the ongoing challenges in enabling their progression to senior positions had mirrored national trends.
12.2.	**Workforce Disability Equality Standard Report (WDES) (including action plan)**
	12.2.1. MS presented the Workforce Disability Equality Standard Report (WDES) for the period ending 31 March 2025 and action plan, noting this was also a statutory report that must be published. 12.2.2. MS highlighted the following: • The number of staff who were confident to disclose that they considered themselves to be disabled had increased from 5.6% in 2024 to 6.7% in 2025. This reflected the improved confidence following the introduction of the Reasonable Adjustments Policy and disability passports. The creation of the disability advice service had been welcomed by both managers and staff. The Trust had also improved the policies around flexible working and provided improved supportive tools, for example zoom text. • Disabled applicants were less likely to be appointed than non-disabled applicants and work was underway to close the gap and this included working with St Helen College and the St Helens Council to support people with a disability into the workforce. • Disabled staff reported higher levels of bullying and harassment and lower feelings of being valued compared to non-disabled colleagues. This mirrored the national trends and whilst MWL was slighter better than the national picture, further work was required. • Disabled staff were less confident about career opportunities compared to non-disabled colleagues. It was noted that there were now no disabled voting members on the Trust Board, which would be an area of focus for future recruitment. 12.2.3. CE asked whether information obtained from exit interviews was triangulated with the WDES and WRES data. MS responded that although there had been a considerable focus on exit interviews to try and reduce turnover, the data had not been analysed in respect of disability or ethnicity. MS agreed to build this into the future reporting to the People Performance Council. 12.2.4. GB felt that the action plan could be further strengthened in relation to career progression. MS agreed to review this and report via the regular progress reports to the SPC. **RESOLVED:** The Board **noted** the Workforce Reports and **approved** the action plans

13.	**TB25/083 MWL Green Plan 2025-28**
	13.1. NB presented MWL Green Plan 2025-28 and noted that, in October 2020, the NHS had committed to delivering net zero by 2040 and each Provider Trust had been asked to develop a three year Green Plan to set out the local ambition and actions to reduce carbon emissions. 13.2. As the legacy trusts had remained separate legal entities at that time, two distinct Green Plans had been developed and approved by the Trust Board (for St Helens and Knowsley Teaching Hospitals NHST) and Strategy and Operations Committee (for Southport and Ormskirk Hospital NHST). 13.3. The MWL Green Plan for 2025 to 2028 detailed the next stage of the Trust's journey to net zero. NB highlighted that the former trusts were different in terms of efficiency of their buildings, the energy systems and the nature of the services provided, and this had meant the carbon emissions baseline had needed to be recalculated. The former STHK sites also had access to more nuanced information, largely due to Public Finance Initiative (PFI) and contractual reporting requirements as well as more modern building management systems. However, the datasets had been successfully combined to inform the first MWL Green Plan. 13.4. The MWL Green Plan followed the NHSE model template and addressed each of the nine priority areas. The plan also included three core objectives: • Reduce carbon, waste and water • Improve air quality • Eliminate avoidable single use plastic 13.5. The Estates and Facilities team would hold the Green Plan and co-ordinate the actions, however delivery of the plan involved a whole organisational response. 13.6. Since July 2023 MWL has achieved a 3,473 tonne CO2e reduction and had secured £11.8m of new investment to support decarbonisation and solar energy and upgraded a significant proportion of lighting to LED via backlog maintenance and lifecycle investments. NB explained that NHSE Estates calculated the carbon reduction figures centrally for each NHS organisation, and this information was published annually. 13.7. CS commended the comprehensive plan and the work already undertaken to reduce carbon emissions and asked if there was a target reduction for 2028. NB confirmed that the reduction trajectory was included in the table on page 20 of the report. CS suggested that this table be moved forward in the document to emphasis the scale to the ambition. 13.8. SR commented that was important to consider the target within the context of the UK national government policies on climate change and net zero, as it the national target changed this would impact the ability of the NHS to

	achieve net zero. NB agreed, especially as most of the organisation's carbon footprint originated from incoming goods and services rather than direct activities, which made the situation complex. **RESOLVED:** The Board **approved** the MWL Green Plan 2025-28
14.	**TB25/084 Freedom to Speak Up Annual Report 2024/25**
	14.1. AMS, on behalf of SO, presented the 2024/25 Freedom to Speak Up Annual Report and noted that although there was a national requirement to produce a report every two years, the Trust had decided to continue with annual reports. Freedom to Speak Up (FTSU) was a key tenant in the Trust values and culture. 14.2. AMS highlighted the following: 14.2.1. 132 concerns had been raised to the FTSU Guardians in 2024/25 which was a 10% increase compared to the preceding year. There had been an increased focus on raising the profile of FTSU and this had included awareness sessions, leadership training and the recruitment and training of additional FTSU Champions. 14.2.2. Staff were encouraged to raise concerns using different methods including anonymously. FTSU aimed to encourage greater openness and freedom for staff to raise concerns. A review had been undertaken of the two highest-performing trusts in the NHS National Staff Survey which had found both of these trusts had received a higher volume of FTSU concerns than MWL. A higher number of concerns should be regarded as positive, as it demonstrated that the FTSU system was trusted by staff. 14.2.3. Of the 2024/25 concerns: • 58% were raised openly, which indicated that staff felt confident to identify themselves and specify the issue. • Only 19% of concerns were raised anonymously. • 23% were raised confidentially, where the staff member's name was declared to the FTSU Guardian or Champion but not disclosed further. 14.2.4. AMS noted that whilst it was important for staff to be aware of their ability to raise concerns anonymously, the increased openness in the reporting of concerns was a positive indicator for the culture of the Trust. 14.2.5. The main themes were: • Worker safety and wellbeing (75) • Inappropriate attitudes or behaviours (66) • Patient safety / quality (25) • Bullying or harassment (19) 14.2.6. There were four Trust FTSU Guardians and 39 FTSU champions across the different hospital sites who assisted staff by signposting how to raise a concern. AMS noted that the Champions also signposted to other routes where more appropriate. .

	14.2.7. Nursing and Midwifery staff raised the most FTSU concerns but this was proportionate as they were the largest staff group. 14.2.8. There had been one case where detriment as a result of speaking up had been reported. The initial concern raised by the staff member was reviewed and action taken. 14.2.9. The last NHS Staff survey had indicated that 64% of staff were confident in raising a concern compared to 60% nationally. 14.2.10. 53% of staff reported they were confident that the organisation would address their concerns and even though the Trust was above the national average of 48% it was recognised more work was needed in this area. 14.3. The 2025/25 action plan included the introduction of the active bystander training and would also pick up any recommendations from the Thirlwall inquiry, when this was published. 14.4. RC commented that he and SC had attended a Teams Talk at St Helens Hospital which had focused on FTSU and one of the FTSU Guardians had addressed the staff attending. There was a variability in staff's awareness of FTSU, but a strong culture of being able to escalate concerns to their managers or with people outside of the immediate team. RC therefore felt there was more work to do to ensure all staff were aware of the FTSU provision and how it access it. 14.5. GB suggested staff could be asked if they were aware of FTSU as part of the annual appraisal. RC responded that the current appraisal documentation asked staff if they wanted to raise any concerns but did not signpost staff to FTSU, and it was important to build trust and confidence in line managers as the first step in resolving any concerns rather than always bypassing them. 14.6. SC commented that it had been useful to talk to staff about their experiences and be able to raise the profile of FTSU, although he reflected that from what he had observed it was already well publicised and promoted across the organisation. AMS commented that one of the key roles of the FTSU champions was to raise awareness, however, this feedback indicated there was still some gaps and this would be discussed with the FTSU guardians. **RESOLVED:** The Board **noted** the Freedom to Speak Up Annual Report 2024/25
Concluding Business	
15.	**Effectiveness of Meeting**
	15.1. GB reflected on the discussion around the WRES and WDES and commented that she had been assured by the gradual progress being made in a number of areas.
16.	**Any Other Business**

	16.1. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.01 The next Board meeting would be held on **Wednesday 26 November 2025 at 09:30.**

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

Trust Board (Public)
Matters Arising Action Log

Mersey and West Lancashire Teaching Hospitals NHS Trust

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

Action Log Number	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
21	24/09/2025	**TB25/072 Statutory Pay Gap Annual Declaration 2024/25**	MS and the CMO to review the current medical leadership structure to better understand if roles were more attractive to male gendered staff	MS / SD	Jan-26		
23	29/10/2025	**TB25/076 Integrated Performance Report** 6.2 Operational Indicators	GB asked about productivity and how this would be measured. LN reported that a detailed report had been presented at F&P Committee and undertook to circulate the presentation to Board members Update (21/11/2025) Copy of presentation to be circulated.	LN	Nov-25		**Completed**
24	29/10/2025	**TB25/078 Corporate Risk Register**	MG to review risks 5 and 23 to determine if could be combined into a single Corporate Risk Register (CRR) risk.	MG	Jan-26		
25	29/10/2025	**TB25/080 Aggregated Incidents, Complaints and Claims Report (Q2)**	SO to provide an update on the high rate of community acquired pressure ulcers at a future Quality Committee	SO	Jan-26		**Delegated to Quality Committee**

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
13	30/07/2025	**TB25 /058 Board Assurance Framework**	BAF 1 additional assurance to be amended to read 'Response to NW Clinical Senate Report and *JOSG'*.	NB	Oct-25	**29/10/2025** - BAF 1 updated to read 'Response to NW Clinical Senate Report and JOSG'	**Action closed**
14	30/07/2025	**TB25/059 Aggregated Incidents, Complaints and Claims Report (Q1)**	MS asked when the review of general surgery claims that was being undertaken by Hill Dickinson would be concluded. PW responded that he did not have this information. The expected end date of the Surgery Claims review would be included in the next report.	SO	Oct-25	**29/10/2025 -** An update was provided under Agenda Item 10 (TB25/080 Aggregated Incidents, Complaints and Claims Report (Q2).	**Action closed**
18	24/09/2025	**TB25/067 Integrated Performance Report** 7.2 Operational Indicators	LN to explore if the LoS performance could be reported to both exclude and include patients classified as NCTR and ready for discharge.	LN	Oct-25	**29/10/2025** - an update was provided under Agenda Item 6 (TB25/076 / 6.2 Operational Indicators) .	**Action closed**
19	24/09/2025	**TB25/067 Integrated Performance Report** 7.2 Operational Indicators	SO to confirm the number of complaints received about waiting times from patients on cancer pathways. <u>Update</u> (24/09/2025) SO advised that there had been no complaints received regarding cancer wait times in the preceding 12 months.	SO	Oct-25	**29/10/2025 -** SO advised that there had been no complaints received regarding cancer wait times in the preceding 12 months	**Action closed**

20	24/09/2025	**TB25/068 Committee Assurance Reports** 8.4 Strategic People Committee	MS to investigate whether the reported AHP vacancy rate was attributable to particular professions within the AHPs or whether it was consistent across all areas and to provide further information.	MS	Oct-25	he AHP vacancy rate, which had previously risen, has now fallen back below target in September. The most significant gaps were identified in Occupational Therapists (OTs), Operating Department Practitioners (ODPs), Physiotherapists, and Radiographers. Recruitment pipelines are in place to address the gaps, with the following expected by December: * OTs: 7.12 WTE * ODPs: 12.8 WTE + 2 WTE apprentices * Physiotherapists: 16.35 WTE * Radiographers: 4 WTE Further monitoring will continue to ensure progress is sustained.	**Action closed**
22	24/09/2025	**TB25/073 2025/26 Winter Plan**	LN to confirm that Quality and Equity Impact Assessment had been received and was reviewed by the Executive Committee and that the Winter Plan was approved.	LN	Oct-25	**29/10/2025** - QIA undertaken and received Executive approval. The Winter Plan has been submitted by the NHSE deadline.	**Action closed**

Title of Meeting	**Trust Board**		**Date**	26 November 2025
Agenda Item	**TB25/087**			
Report Title	Integrated Performance Report			
Executive Lead	Gareth Lawrence, Chief Finance Officer			
Presenting Officer	Gareth Lawrence, Chief Finance Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

The Integrated Performance Report provides an overview of performance for MWL across four key areas:

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

Executive Summary

Performance for MWL is summarised across 29 key metrics. Quality has 11 metrics, Operations 11 metrics, Workforce 4 metrics and Finance 3 metrics.

Financial Implications

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

Quality and/or Equality Impact

The 11 metrics for Quality provide an overview for summary across MWL.

Recommendations

The Trust Board is asked to note performance for assurance.

Strategic Objectives

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

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

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-25	86.8	100	90.4	Best 30%
FFT - Inpatients % Recommended	Oct-25	93.9%	90.0%	94.0%	Worst 40%
Nurse Fill Rates	Oct-25	97.5%	90.0%	98.1%	
C.difficile	Sep-25	8	97	58	
E.coli	Sep-25	10	151	83	
Hospital Acq Pressure Ulcers per 1000 bed days	Aug-25	0.05	0.00	0.09	
Falls ≥ moderate harm per 1000 bed days	Oct-25	0.13	0.00	0.11	
Stillbirths (intrapartum)	Oct-25	0	0	0	
Neonatal Deaths	Oct-25	1	0	1	
Never Events	Oct-25	0	0	2	
Complaints Responded In 60 Days	Oct-25	58.8%	80.0%	53.0%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Sep-25	65.8%	77.0%	65.9%	Worst 10%
Cancer 62 Days	Sep-25	76.0%	85.0%	78.8%	Best 20%
Ambulance Arrival to Vehicle Handover: % <45 mins	Oct-25	82.2%	100.0%	87.3%	
A&E Standard (Mapped)	Oct-25	78.0%	78.0%	78.7%	Best 30%
Average NEL LoS (excl Well Babies)	Oct-25	4.0	4.0	3.9	Best 30%
% of Patients With No Criteria to Reside	Oct-25	22.2%	10.0%	21.1%	
Discharges Before Noon	Oct-25	19.6%	20.0%	18.8%	
G&A Bed Occupancy	Oct-25	97.9%	92.0%	98.0%	Worst 10%
Patients Whose Operation Was Cancelled	Oct-25	1.1%	0.8%	1.0%	
RTT % less than 18 weeks	Oct-25	63.9%	92.0%	63.9%	Best 30%
18 weeks: % 52+ RTT waits	Oct-25	2.0%	1.0%	2.0%	Worst 50%

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Oct-25	89.0%	85.0%	89.0%	
Mandatory Training	Oct-25	89.7%	85.0%	89.7%	
Sickness: All Staff Sickness Rate	Oct-25	7.3%	5.0%	6.5%	
Staffing: Turnover rate	Oct-25	0.7%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Oct-25		36,681	18,854	
Cash Balances - Days to Cover Operating Expenses	Oct-25	0.7	10		
Reported Surplus/Deficit (000's)	Oct-25		-25,190	-30,687	

Board Summary - Quality

Quality

Mortality Data: HSMR: The Trust is in discussions with our supplier regarding delays in HSMR data. The latest SHMI for the period Jun-24 to May-25 is 0.99.

FFT: October positive score 93.9%, 0.1% below internal target of 94% (Most recent national average score August-25 is 95%). 2024 National Inpatient Survey results have been received and supporting action plan now implemented.

Pressure Ulcers: Validation now complete for August with 2 category 2 HAPUs with lapses. Tissue Viability Strategy group now established to promote consistency of assessment and management of wounds across MWL.

Falls: Following review, there are now 3 validated falls with a level of harm of moderate or above. 2 moderate and 1 severe incident. Learning reviews are underway for all incidents and linking to the enhanced levels of care pilot to ensure appropriate levels of surveillance. The new Falls Practitioner commenced in role in November 2025 to support staff training in falls prevention.

Neonatal Deaths: Category 1 caesarean section for placental abruption resulting in Neonatal Death. Case also reportable to MNSI/StEIS/PMRT.

Never Events: There were no reported never events in October

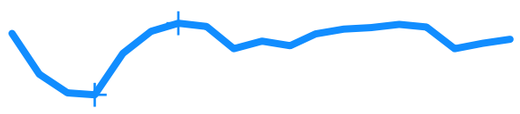
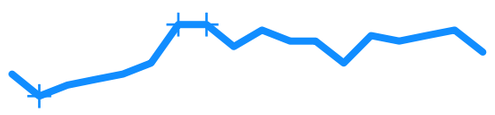
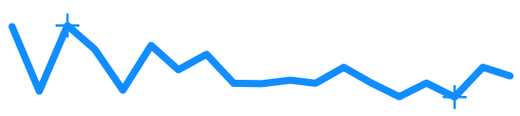
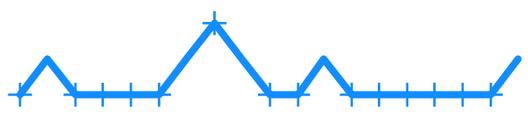
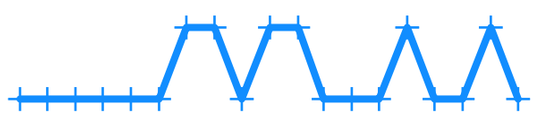
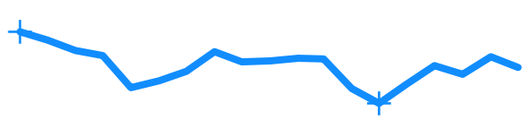
Complaints: October has shown a nominal increase in the number of stage 1 complaints received. It should be noted that for the first time there is an almost equal split of complaints at each site.
The majority of the new complaints relate to the Medicine & Urgent Care Division. 37 areas across the Trust all had at least 1 new complaint.
With regards to the number of complaints closed within the agreed Trust 60 working day target October compliance is recorded at 67% which is consistent with last month's performance.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Mar-25	86.8	100	90.4	Best 30%	
FFT - Inpatients % Recommended	Oct-25	93.9%	90.0%	94.0%	Worst 40%	
Nurse Fill Rates	Oct-25	97.5%	90.0%	98.1%		
C.difficile	Sep-25	8	97	58		
E.coli	Sep-25	10	151	83		
Hospital Acq Pressure Ulcers per 1000 bed days	Aug-25	0.05	0.00	0.09		
Falls ≥ moderate harm per 1000 bed days	Oct-25	0.13	0.00	0.11		
Stillbirths (intrapartum)	Oct-25	0	0	0		
Neonatal Deaths	Oct-25	1	0	1		
Never Events	Oct-25	0	0	2		
Complaints Responded In 60 Days	Oct-25	58.8%	80.0%	53.0%		

Board Summary - Operations

Operations

Urgent Care Pressures A&E
4-Hour performance declined in October, achieving 71.6% (all types). Trust performance is below National (74.1%), and ahead of C&M (71.9%). The Trusts mapped 4-Hour performance achieved 78.0%.

Patient Flow
Bed occupancy across MWL averaged 105.2% in October equating to 87.3 patients - an ongoing trend of high occupancy. There was a peak of 129 patients (56 at S&O, 79 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 7% higher than last October, driven by a 19% increase in 0 LOS activity, 1+ day LOS activity was -4% higher than last year. Southport had a 70.7% increase in 0 LOS from October 24 to October 25, driven by the use of the new ED SDEC. Average length of stay for emergency admissions remains high, at 8.9 at S&O and 8.2 at StHK, with an overall average of 8.4 days, the impact of non CTR patients being 22.2% at Organisation level, 1.2% lower than September but 4.3% higher than October 2024 (27.4% S&O and 19.2% StHK).

Elective Activity
The Trust had 1,562 52-week waiters at the end of October, (465 S&O and 1,097 StHK), 7 65-week waiters and 5 zero 78-week waiters.
The 52-week position is a decrease of 205 from September and the 65-week waiters have decreased by 48 from September to October. 18-Week performance in October for MWL was 63.9%, S&O 64.9% and StHK 63.5%. This was ahead of national performance (latest month September) of 61.8% and C&M regional performance of 59.2%.

Cancer
Cancer performance for MWL in September improved slightly, at 65.8% for the 28 day standard (target 77%), with Southport achieving 56.9% and St Helens performance being 72.4%. Latest published data (September) shows national performance of 73.9% and C&M regional performance of 70.6%. Performance for 62-day reduced, achieving 76% (target 85%), with Southport achieving 55.9% and St Helens 87.2%. C&M performance was 72.7% and National 67.9%. Tumour site specific improvement plans are in place which set out the key actions being taken to achieve the 28 day and 62 day standards for 2025/26.

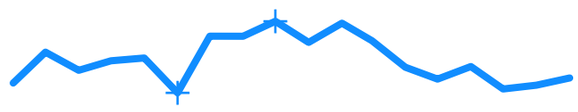
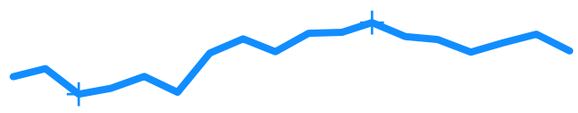
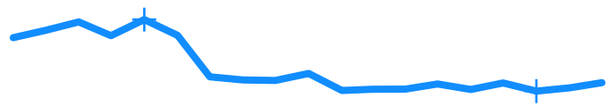
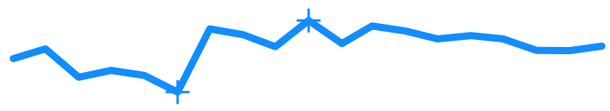
Diagnostics
Diagnostic performance in October was 94.1% for MWL, failing to achieve the 95% target, with S&O achieving 93.9% and StHK 94.2%. MWL performance is ahead of national performance (latest month September) of 77.5% and C&M regional performance of 87.6%.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Sep-25	65.8%	77.0%	65.9%	Worst 10%	
Cancer 62 Days	Sep-25	76.0%	85.0%	78.8%	Best 20%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Oct-25	82.2%	100.0%	87.3%		
A&E Standard (Mapped)	Oct-25	78.0%	78.0%	78.7%	Best 30%	
Average NEL LoS (excl Well Babies)	Oct-25	4.0	4.0	3.9	Best 30%	
% of Patients With No Criteria to Reside	Oct-25	22.2%	10.0%	21.1%		
Discharges Before Noon	Oct-25	19.6%	20.0%	18.8%		
G&A Bed Occupancy	Oct-25	97.9%	92.0%	98.0%	Worst 30%	
Patients Whose Operation Was Cancelled	Oct-25	1.1%	0.8%	1.0%		
RTT % less than 18 weeks	Oct-25	63.9%	92.0%	63.9%	Best 30%	
18 weeks: % 52+ RTT waits	Oct-25	2.0%	1.0%	2.0%	Worst 50%	

Board Summary - Workforce

Workforce

Mandatory Training
The Trust continues to exceed its mandatory training target, maintaining performance at 89.7% against a target of 85%. Targeted support remains in place to enable front-line clinical staff to access training, ensuring continued compliance and improvement.

Appraisals
Appraisal compliance is positively exceeding the 85% target at 89% in October 25. .

Sickness Absence
Sickness absence has increased in September to 7.3%, remaining above the Trust target of 5%.

Top 3 reasons for sickness absence:

Anxiety/stress/depression/other psychiatric illnesses
Other musculoskeletal problems
Chest and Respiratory

A comprehensive sickness absence improvement plan is in place, with progress monitored through the People Performance Council and Strategic People Committee. Targeted initiatives under the Looking After Our People pillar of the Trust People Plan are being implemented, and the Absence Support Team continues to provide focused support to teams with the highest levels of absence. Despite the high levels of support, it is recognised that absence continues to be a key area of concern. Plans are being progressed to undertake a deep dive into absence data, with a view to key stakeholders coming together to consider what immediate, medium and long term actions can be taken forward to drive down absence in a sustained way.

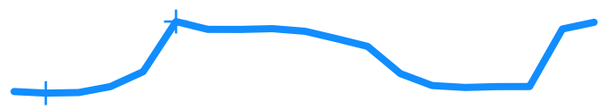
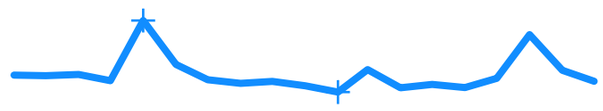
Turnover
In-month turnover has decreased in September to 0.7% against a target of 1.1%.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Oct-25	89.0%	85.0%	89.0%		
Mandatory Training	Oct-25	89.7%	85.0%	89.7%		
Sickness: All Staff Sickness Rate	Oct-25	7.3%	5.0%	6.5%		
Staffing: Turnover rate	Oct-25	0.7%	1.1%	0.8%		

Board Summary - Finance

Finance

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

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

Surplus/Deficit – At the end of Month 7, the Trust is reporting an adjusted position of £30.7m deficit. Excluding deficit support funding the adjusted position is £38.2m deficit, £4.6m better than plan. This includes the impact of the revised pay award and industrial action costs which are offset against cost reductions delivered ahead of plan.

CIP - The Trust's CIP target for financial year 2025/26 is £48.2m, all if which is to be delivered recurrently. As at Month 7, the Trust has successfully transacted CIP of £28.5m year to date, £1.9m above plan. 100% of the £48.2m recurrent target is covered by fully developed schemes.

Cash - At the end of M7, the Trust's cash balance was £1.7m. As part of the original plan submitted to NHSE, the Trust assumed the receipt of £30m deficit support funding by the end of the financial year. As at M7, only Q1 2025/26 has been received, the Trust continues to monitor cash closely and implement mitigations to the removal of deficit support funding. To date, the Trust has received PDC support of £10.9m (September) and £11m (October) but has not been supported in November.

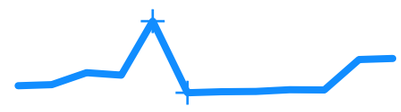
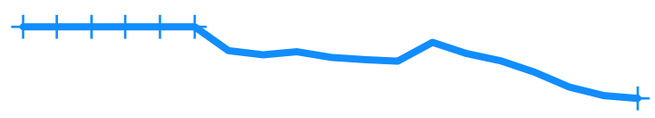
Capital - The original capital plan for the year is £64.6m (including PFI lifecycle and lease remeasurements). Capital expenditure for the year to date [including PFI lifecycle maintenance and lease remeasurements] totals £18.8m, which is

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Oct-25		36,681	18,854		
Cash Balances - Days to Cover Operating Expenses	Oct-25	0.7	10			
Reported Surplus/Deficit (000's)	Oct-25		-25,1...	-30,6...		

How to Interpret - Summary Table

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

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

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

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

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

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

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

Metric Category Description - Quality

Quality Metrics

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

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

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

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

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

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

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

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

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

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

Metric Category Description - Operations

Operational Metrics

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

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

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

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

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

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

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

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

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

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

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

Metric Category Description - Workforce

Workforce Metrics

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

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

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

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

Metric Category Description - Finance

Finance Metrics

Capital Spend £M
Capital Spend £M

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

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy STHK

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

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-25	79.2	100	89.3	
FFT - Inpatients % Recommended	Oct-25	93.3%	94.0%	93.7%	
Nurse Fill Rates	Oct-25	95.0%	90.0%	96.5%	
C.difficile	Sep-25	5		37	
E.coli	Sep-25	4		48	
Hospital Acq Pressure Ulcers per 1000 bed days	Aug-25	0.00	0.00	0.07	
Falls ≥ moderate harm per 1000 bed days	Oct-25	0.08	0.00	0.12	
Stillbirths (intrapartum)	Oct-25	0	0	0	
Neonatal Deaths	Oct-25	1	0	1	
Never Events	Oct-25	0	0	0	
Complaints Responded In 60 Days	Oct-25	55.6%	80.0%	53.0%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Sep-25	72.4%	77.0%	75.4%	
Cancer 62 Days	Sep-25	87.2%	85.0%	86.1%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Oct-25	79.2%	100.0%	82.7%	
A&E Standard (Mapped)	Oct-25				
Average NEL LoS (excl Well Babies)	Oct-25	4.2	4.0	3.9	
% of Patients With No Criteria to Reside	Oct-25	19.2%	10.0%	19.8%	
Discharges Before Noon	Oct-25	21.4%	20.0%	19.6%	
G&A Bed Occupancy	Oct-25	98.3%	92.0%	98.3%	
Patients Whose Operation Was Cancelled	Oct-25	1.1%	0.8%	1.1%	
RTT % less than 18 weeks	Oct-25	63.5%	92.0%	63.5%	
18 weeks: % 52+ RTT waits	Oct-25	2.0%	1.0%	2.0%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Oct-25	89.6%	85.0%	89.6%	
Mandatory Training	Oct-25	89.3%	85.0%	89.3%	
Sickness: All Staff Sickness Rate	Oct-25	7.2%	5.0%	6.6%	
Staffing: Turnover rate	Oct-25	0.7%	1.1%	0.9%	

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

Board Summary

Legacy S&O

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

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-25	108.5	100	93.7	
FFT - Inpatients % Recommended	Oct-25	95.3%	90.0%	95.0%	
Nurse Fill Rates	Oct-25	99.8%	90.0%	99.6%	
C.difficile	Sep-25	3		21	
E.coli	Sep-25	6		35	
Hospital Acq Pressure Ulcers per 1000 bed days	Aug-25	0.16	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Oct-25	0.23	0.00	0.09	
Stillbirths (intrapartum)	Oct-25	0	0	0	
Neonatal Deaths	Oct-25	0	0	0	
Never Events	Oct-25	0	0	2	
Complaints Responded In 60 Days	Oct-25	66.7%	80.0%	53.1%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Sep-25	56.9%	77.0%	50.9%	
Cancer 62 Days	Sep-25	55.9%	85.0%	61.4%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Oct-25	87.6%	100.0%	95.4%	
A&E Standard (Mapped)	Oct-25				
Average NEL LoS (excl Well Babies)	Oct-25	3.6	4.0	3.9	
% of Patients With No Criteria to Reside	Oct-25	27.4%	10.0%	23.4%	
Discharges Before Noon	Oct-25	17.7%	20.0%	18.0%	
G&A Bed Occupancy	Oct-25	97.1%	92.0%	97.3%	
Patients Whose Operation Was Cancelled	Oct-25	1.4%	0.8%	1.0%	
RTT % less than 18 weeks	Oct-25	64.9%	92.0%	64.9%	
18 weeks: % 52+ RTT waits	Oct-25	2.1%	1.0%	2.1%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Oct-25	87.8%	85.0%	87.8%	
Mandatory Training	Oct-25	90.5%	85.0%	90.5%	
Sickness: All Staff Sickness Rate	Oct-25	7.6%	5.0%	6.3%	
Staffing: Turnover rate	Oct-25	0.7%	1.1%	0.7%	

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 November 2025
Agenda Item	**TB25/088 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the five Executive Committee meetings held in October 2025		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were five Executive Committee meetings held during October 2025. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. The weekly vacancy control panel decisions were also reported, at each committee meeting.		
02 October 2025		
Patient Level Costings (PLC)	• The Director of Integration introduced the paper which presented work undertaken by Mersey Care NHSFT (Population Health Management) to analyse individuals in St Helens who had the greatest health needs and incurred the highest healthcare costs over multiple years. • This analysis demonstrated that between 2022/23 and 2024/25 there were 740 households with 1,174 individuals that accounted for 58-60% of healthcare costs in those years. Most of these households were in the most deprived areas of the town and respiratory and cardiac illnesses made up the majority of hospital admissions. • The Committee had discussed how targeted interventions could help prevent these illnesses or improve outcomes, in support of the Neighbourhood Health Pioneer Pilot Programme.	Assurance
Service Improvement Strategy	• The Director of Strategy introduced the draft Service Improvement Strategy. • The document was supported by planned implementation approach and ambition for training staff in a single service improvement methodology. • Committee reviewed and commented on the draft, and it was agreed additional focus would be added to link to the Trust's vision for Five Star	Assurance

	Patient Care and to clarify the approach for transferring projects from service improvement to business as usual. • A final draft would be developed for presentation to a future Trust Board.	
Procedural Document Update (September)	• The Chief Nursing Officer introduced the report. There were 203 overdue procedural documents, and Committee discussed the challenges to review and harmonise policies. • It was agreed that work would be undertaken with the Divisions, and Policies, Standard Operating Procedures (SOPs) and guidelines would be separated and prioritised. • It was noted that across many areas it had been reported that policies were in the final stages of consultation, prior to approval, providing assurance that progress was being made.	Assurance
NHS England Nursing and Midwifery Job Evaluation Project	• The Chief People Officer provided a briefing on the national nursing and midwifery job evaluation project. • The first phase is to gather and review all current band 5 nursing job descriptions against the national Agenda for Change profiles. • The second phase would focus on developing new generic job descriptions, covering the core nursing competencies. • Regular updates would be made to the Committee.	Assurance
NetCall – Patient Reminder Messages	• The Director of Informatics presented the current messages sent to legacy STHK patients via the NetCall system. • The investigation had identified a lack of standardisation across sites and specialities, and Committee supported proposals to move to a uniform standard across MWL, as far as possible with the current separate Electronic Patient Records (EPR) systems. • Data on the usage and impact of NetCall was also shared and it was agreed that this would be provided to operational managers regularly to assist in the management of outpatients and waiting lists. • It was agreed that further work be undertaken with the Operations team to develop the standard messaging schedule.	Assurance
Standard Rate Card – Northwest	• The Chief People Officer presented proposals for Cheshire and Merseyside (C&M) providers to	Approval

	adopt the same basic rate card as Greater Manchester and Lancashire and South Cumbria Integrated Care Boards (ICBs) for new bank and locum medical staff shifts, as instructed by the ICB Turnaround Director. • Committee discussed the implications and risks to implementation but agreed the principle of adopting a standard rate card if this was agreed by all providers across the ICBs.	
Nurse Safe Staffing Report - August	• The Chief Nursing Officer presented the report. • Registered Nurse (RN) fill rates had been 94.97% which reflected the summer holiday period. • Health Care Assistant (HCA) bank fill rates had reduced due to the previous approval to increase HCA establishments across high use areas. • One pressure ulcer had been linked to a ward that was below the planned number of RNs on shift, this was being investigated.	Assurance
Partnership Update	• The Director of Integration presented the report which focused on changes to the ICB leadership team and the Neighbourhood Health Pioneer programmes in St Helens and Sefton. There would be monthly meetings of the Pioneer Task Groups.	Assurance
09 October 2025		
Review of Cost Improvement Programme (CIP) Quality Impact Assessment (QIA) Policy	• The Chief Nursing Officer reported on the actions being taken to refresh the CIP QIA Policy. • The new policy was expected to be approved in November and would reflect the Divisional operating model and role of the Divisional leadership teams in ensuring QIAs were completed prior to CIP schemes being transacted.	Assurance
Financial Improvement Action Plan	• The Chief Finance Officer presented the progress against the financial improvement plan. • Several actions overlapped with the Finance Improvement Group (FIG) actions and centred around reducing variable spend on pay and increasing productivity and performance. • Committee agreed to focus the next round of Divisional Performance Reviews on these areas to ensure there were speciality level plans in place.	Assurance
Freedom of Information (FOI) Report – September	• The Director of Informatics presented the report. • Compliance for the 20-day response time target remained below target.	Assurance

	• The number and complexity of the FOI requests continued to increase and often required multiple teams/departments to contribute to the response. • The FOI team continue to review and add to the Trust published information/publication scheme.	
Mandatory training and appraisal compliance - September	• The Chief People Officer reported that at the end of the annual appraisal window over 85% of agenda for change staff had completed an appraisal. • Mandatory training compliance was 89% against the 85% target. • The new integrated MWL Training Needs Assessment (TNA) for mandatory and compulsory training had been implemented, and this was recognised as causing temporary changes in compliance as some staff needed to complete different TNA subjects. • Actions were being taken to work with the Local Negotiating Committee (LNC) to improve Medical and Dental staff mandatory training compliance.	Assurance
Getting the Basics Right – 10 Point Action Plan	• The Chief People Officer presented the new national guidance on improving the working lives of resident doctors. • MWL and the Lead Employer (LE) would develop local implementation plans, to be presented to the Committee in November.	Assurance
16 October 2025		
Shuttle Bus Service Review	• The Director of Corporate Services presented the report. • The shuttle bus service had originally been commissioned for staff and patients following the consultation on the new Whiston and St Helens Hospitals, because most outpatient facilities were being provided at the St Helens site. • A survey of the shuttle bus had confirmed it remained well used, conveying an average of 320 passengers per day, of which 52% were patients and 48% were staff. • Larger buses meant that two were in constant use to maintain the regular service and the number of drivers had reduced. • A further review would be undertaken when the leases on the current buses expired to assess the most cost effective way of providing the service.	Assurance
Board Assurance Framework (BAF)	• The Director of Corporate Services presented the proposed changes to the BAF to be recommended to the Trust Board.	Assurance

Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the RMC assurance report from the October meeting. • A concern was escalated in relation to the number of risks that were overdue for review, and actions proposed to support the Divisions and Services to strengthen local risk management processes. • Following the implementation of InPhase across MWL, the Risk Management Framework was also being reviewed to further standardise practice. • The RMC had received the assurance report from the Claims Governance Group, for new claims received in July and August.	Assurance
Integrated Performance Report (IPR) - September	• The Chief Finance Officer presented the IPR metrics and Committee discussed the commentary that needed to be completed for the Committee Performance Reports to be issued. • Committee noted the increased % of Non-Criteria to Reside (NCTR) patients which had risen by 2% in the month with a year to date (YTD) position of 20.9% of beds against the target of 10% and the impact this was already having on patient flow ahead of winter.	Assurance
Lyrebird Automated Voice to Text (AVT) system demonstration	• The Director of Informatics introduced Lyre Health who demonstrated the Lyrebird AVT system, and how it could be used in a variety of clinical settings, including outpatients, Multidisciplinary Team (MDT) meetings and ward rounds, producing patient letters, GP correspondence and updates to the patient notes. • A pilot was proposed in Trauma and Orthopaedics (T&O) and Dermatology in November. • It was noted that NHSE NW had awarded funding to C&M ICB to expand the use of AVT, and a collective procurement process was being undertaken.	Assurance
NHS Oversight Framework - Provider Capability Self-Assessment	• The Director of Corporate Services presented the proposed declaration for each capability statement and the supporting sub-criteria. • Committee reviewed each sub-criteria to ensure consistency and a shared understanding of the interpretation of the NHSE text and how they impacted each capability domain. • Several changes were agreed to the version to be presented to the Trust Board for approval.	Approval
Freedom to Speak Up (FTSU) Annual Report 2024/25	• The Deputy CEO presented the draft FTSU annual report for review, prior to presentation to the October Trust Board.	Approval

	• The report provided assurance that the Trust's FTSU process was operating effectively and being accessed by staff.	
Corporate Benchmarking 2024/25	• The Chief Finance Officer presented the results of the national corporate services costs benchmarking exercise for 2024/25. • The report demonstrated that the MWL corporate costs had reduced by circa £5m compared to 2023/24. • All corporate functions now compared favourably to the national median quartile or lower quartile. • These results provided assurance that MWL's corporate services were provided efficiently compared to other trusts.	Assurance
Month 6 Financial Forecast and Financial Improvement Actions	• The Chief Finance Officer reported the Month 6 position against the agreed financial plan for 2025/26. • Although the Trust remained ahead of plan in month 6 it was acknowledged the agreed plan had assumed a higher level of efficiencies in the second half of the year. • In Month 6 and year to date there had been no benefit recorded in relation to the £33m of system financial improvement schemes, therefore further local mitigations were being identified, which currently were valued between £18.7m and £22.1m • The contractual income outstanding from Lancashire and South Cumbria and Greater Manchester ICBs also remained a risk. • The PricewaterhouseCoopers International Limited (PwC) balance sheet review was on-going.	Assurance
PWC Financial Grip and Control Review	• The Chief Finance Officer presented the PWC report and action plan, noting many of the actions had been identified in a similar review the previous year and were either implemented or in progress. • Each action had a lead responsible Director and progress would be tracked to monitor delivery and impact.	Assurance
Green Plan 2025-2028	• The Director of Corporate Services presented the draft Green Plan 2025-2028 for review. • This was the first MWL Green Plan and detailed the achievements of the legacy organisations since 2022 and the investment secured to progress the NHS net zero ambition.	Assurance

	• Following review, the Green Plan was endorsed for recommendation to the Trust Board for approval.	
23 October 2025		
Patient Digital Communication	• The Director of Informatics presented the review of digital messaging to patients across MWL from the NetCall System (legacy STHK patients) and Patient Portal (legacy S&O patients). • The recommendation from the Digital and Operational teams was to harmonise messaging protocols to 21-, 14- and 7-day reminders for outpatient appointments. • In addition, functionality for patients on elective waiting lists would also be standardised so patients would receive messages when their referral was received and periodically to provide assurance they remained on the waiting list. • Committee were assured that most patients opted into the service, however, remained conscious of patients who were not digitally enabled or who were on several treatment pathways at the same time. • It was agreed that the NetCall and Patient Portal teams would be managed together by the Digital service with an operational lead, to implement consistent protocols and monitor defined engagement and impact metrics.	Assurance
Review of Staff Communications and Engagement	• The Chief People Officer presented the review of the staff communication and engagement processes in place. • In the 2024 staff survey MWL had been 22nd in the country and second in the Northwest for the staff engagement score. • The review had concluded that all the existing methods of communication and engagement were effective in reaching a diverse range of staff and achieved their objectives, however it was recognised that there was a need to ensure consistent messages were reaching all staff throughout the Trust. • Therefore, the introduction of a formal monthly written team brief that would be presented by the CEO and cascaded throughout the organisation was recommended. • It was agreed that a methodology for team brief across MWL and evaluation criteria would be developed for further consideration.	Approval

Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) 2024/25	• The Chief People Officer presented the draft WRES and WDES reports and action plans for review, ahead of presentation to the Trust Board. • Committee noted the gradual progress being made and supported the continuation of the action from the previous year.	Assurance
CQC Well Led Quality Statements Awareness Survey	• The Director of Corporate Services introduced the results of the survey which had been undertaken to assess the understanding of the CQC Well Led Quality Statements. • 38 Board members and senior leaders had been invited to participate, and 27 surveys had been completed. • The areas where leaders felt less confident about articulating the Trust position were being used to inform an action plan.	Assurance
Leng Review	• The Acting Chief Medical Officer presented the report that detailed the actions taken by the Trust to respond to the recommendations of the Leng Review that had been published in July 2025. • The findings of the review had been legally challenged by the union representing Physicians Associates (PA) and Anaesthetic Associates (AA), but until the outcome of this challenge was known the Leng Review recommendations which had been accepted by the Secretary of State for Health and Social Care remained in force. • The Royal College of Emergency Medicine (RCEM) had issued guidance in October 2025 that PA's should work under supervision and not see undifferentiated patients. The Medicine and Urgent Care Divisional Medical Director had ensured that this guidance was being implemented across MWL. • The newly named Physician Assistants and Anaesthetic Assistants would be required to register with the GMC by December 2026.	Assurance
30 October 2025		
EPRR Core Standards Review	• The Chief Operating Officer presented the outcome of the C&M ICB review of the Trust's EPRR core standards self-assessment submission. • The ICB had agreed with the Trust's assessment based on the evidence provided and had noted the progress made. • The outcome letter (attached) was to be shared with the Trust Board	Assurance

November Trust Board Agenda	• The Director of Corporate Services presented the Draft Trust Board agenda for November from the annual work plan and action logs. • The Committee selected the Employee of the Month (EOTM) from the nominations received during October	Assurance
Outpatient Transformation Programme	• The Director of Strategy introduced the report, which presented the revised scope of the programme following the recent refresh. • The scope, objectives, measures of success and timelines were discussed, recognising the short-term focus on maximising current capacity in Q3 and Q4 of 2025/26, and medium-term requirement to standardise processes across MWL and adapt to new technology and the changing nature of outpatient services • The Executive Committee will receive fortnightly progress reports	
Artificial Intelligence (AI) Policy	• The Director of Informatics presented the draft policy for MWL that had been developed by the IT Council, in line with national NHS Guidance. • Committee felt that staff would need an additional practical guide/flow chart to support the policy as this technology was changing quickly. • A revised draft would be presented, incorporating the feedback	Assurance
Workforce Financial Improvement Group Assurance Report	• The Chief People Officer presented the report noting discussions with Divisional leadership teams remained focused on job planning, reducing agency expenditure and reducing roster approval times.	Assurance
Procedural Documents Report (October)	• The Chief Nursing Officer presented the report, noting the reduction in overdue policies to 173 since the last report, with assurance that several more were due to be presented to councils for approval in November and December. 47 further policies were due to expire by January 2026. • Each Division/Service had an improvement plan which was overseen by the lead Director for that area.	Assurance
Emergency Preparedness, Resilience and Response (EPRR) Business Continuity Incident	• The Director of Informatics presented the initial investigation report following the telephony system outage at Southport Hospital on 20 October. • The outage had occurred when the electrical supply was being switched to the new electrical substation. The system had then taken some time	Assurance

	to reboot, resulting in the need to deploy business continuity for emergency 2222 calls for circa 45 minutes • Some initial learning had been identified to improve communications between Estates and IT, and a full EPRR debrief process had been initiated.	

Alerts:

None

Decisions and Recommendations:

Investment decisions taken by the Committee during October 2025 were:

- None

NHS
Cheshire and Merseyside

To:
Lesley Neary
Accountable Emergency Officer (AEO)
Mersey and West Lancashire Teaching Hospitals NHS Trust

Date: 20th October 2025

Dear Lesley,

NHS Cheshire and Merseyside are responsible for gaining assurance on the preparedness of the NHS Trusts within Cheshire and Merseyside, to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to deliver critical services.

This is achieved through the NHS EPRR Annual Self-Assessment Assurance process, which was reviewed by the NHS Cheshire and Merseyside EPRR Team, with the aim to provide constructive feedback to allow for continuous development. This process was achieved by reviewing the evidence submitted for 5 randomly selected core standards from your Trust.

The 5 core standards that were randomly selected for your Trust were:

Core Standard:	Title:	Standard detail:
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
20	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.
23	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)

43	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.
59	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self-presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the

NHS
Cheshire and Merseyside

Core Standard:	Title:	Standard detail:
		decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.

The outcome of the review can be found in appendix 1, whereby we agree with the self-assessment rating based on the evidence supplied.

The documentation supplied is of a consistently good standard. It is clear that significant time and effort has been dedicated to continuously improving EPRR processes across Mersey and West Lancashire.

Next Steps:

1. The AEO is asked to note the outcome of the review.
2. The AEO is asked to present the results of the annual EPRR assurance process and compliance position to the organisations Public Board.

The final detail will be included within the Cheshire and Merseyside Assurance Report which will be presented at the Strategic Local Health Resilience Partnership meeting on Tuesday 11th November 2025, prior to submission to NHS England North West.

Yours sincerely

Anthony Middleton
Director of Performance and Planning / AEO
NHS Cheshire and Merseyside

Appendix 1

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Agree	Substantial evidence supplied to support.
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Agree	Substantial evidence supplied to support.
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrange-	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must:	Agree	Substantial evidence supplied to support.

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
			ments, (*no undue risk to exercise players or participants, or those patients in your care)	• identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning		
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Agree	Substantial evidence supplied to support.
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift	Agree	Updated evidence supplied.

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
			day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee/ Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 November 2025
Agenda Item	**TB25/088 (8.2)**		
Committee being reported	Audit Committee		
Date of Meeting	12 November 2025		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
AC25/037 External Audit Progress Report	Grant Thornton (GT) provided a sector update and an overview on progress towards delivering their external audit responsibilities for 2025/26.	Assurance
AC25/038 Internal Audit Report	MIAA summarised the internal audit progress reports key messages section. MIAA confirmed one report had been finalised and 8 reports were in various stages of progress.	Assurance
AC25/039 MWL Audit Log	Committee received the audit log report which highlighted key movements on the audit log, both in relation to internal and external audit recommendations.	Assurance
AC25/040 Anti-Fraud Progress Report	MIAA presented the anti-fraud progress report from September to October, which summarised the anti-fraud and investigations activity for the period.	Assurance
AC25/041 Conflicts of Interest Review and Action Plan	The Chief Finance Officer presented a report identifying the policies and processes in place that enable designated decision makers to record declarations of interest in line with the Standards of Business Conduct Policy.	Assurance
AC25/042 Financial Reports	The losses and special payments report was presented. Total losses identified as at 30 October was approximately £144k. £372k in total was recorded in 2024/25. The aged debt report was presented. Specific attention was paid towards the age and value of aged debt in the >90 day category, and what actions	Assurance

	would be needed to help reduce these values down going forward. The tenders and quotation waivers report was presented and its contents noted.	
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report

Title of Meeting	**Trust Board**	**Date**	26 November 2025
Agenda Item	**TB25/088 (8.3)**		
Committee being reported	Charitable Funds Committee		
Date of Meeting	06 November 2025		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Head of Charity Report	Updates were provided on the Charity teams activity between June and November 2025 key points included • Creation of a staff Wellbeing fund • Support for the Butterfly co-ordinator role • Whiston Abseil September 2025 • Spinal Unit appeal progress • Christmas plans	Assurance/Decision
Annual Report and Accounts	The Committee approved the MWL Charity Annual Report and Accounts for 2024/25.	Decision
Finance Report	An update of MWL NHS Charity's financial performance and financial position (fund balances) as at 30 September 2025 MWL NHS Charity balance was £1,202m at 30 September 25	Assurance
Review of Charity Risk Register	No change to the risk register has been made since the previous meeting in March 2025.	Assurance
Legacies update and processes	Charitable Funds Committee were asked to approve the transfer of ownership of property included as part of the pending large legacy for the Spinal Unit.	Decision
Summary of Applications received since February 2025	A list of all applications MWL NHS Charity has received since June 2025. A total of six projects has been granted with a total value of £40,000	Assurance

Alerts:
None
Decisions and Recommendation(s):
Charitable Funds Committee were asked to approve • the band 5 Butterfly Co-ordinator role • creation of a staff wellbeing fund • annual report and accounts 2024/25 • the transfer of ownership of property included as part of the pending large legacy for the Spinal Unit.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 November 2025
Agenda Item	**TB25/088 (8.4)**		
Committee being reported	Quality Committee		
Date of Meeting	18 November 2025		
Committee Chair	Claudette Elliott, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Minutes and Action Log	• The minutes of the Quality Committee meeting held on 21 October were approved following some minor amendments. • There were 11 actions due for update in November, and all were approved as completed or updates received as part of the agenda.	Assurance
Quality Committee Corporate Performance Report (CPR).	• The Committee reviewed the Corporate Performance Report for October and noted the following- • Pressure Ulcer validated data for August 2025 with two reported where lapses in care had been identified. Management of wounds and pressure ulcer improvement actions were ongoing, and a review of community acquired pressure ulcers was due to be reported in January. • Falls -one severe harm fall reported noting no new themes following learning reviews. Outcome of the external review and action plan to be reported to the Committee in January. • Inpatient National Early Warning Score (NEWS) completion now 86.2% (target 80%). Emergency Department (ED) NEWS compliance remained below target, with actions agreed to improve performance. • There had been six Maternity reportable incidents in October, and the details of each one was shared with the Committee. • Patient Safety Incident Response Framework (PSIRF) - no new Patient Safety Incident Investigations (PSIIs) reported in October. • Stroke indicators – assurances received that the new national stroke metrics and	Assurance

	performance data had now been published. The Committee would receive report in January explaining the changes to the reporting and the MWL position for each stroke service. Work was on-going with the Business Intelligence (BI) team to align Malnutrition Universal Screening Tool (MUST) reporting across MWL which was expected to be completed for November data.	
Patient Safety Report - September (Inc. Chair's Assurance Report)	• Two PSII's commissioned in September. One Maternity and Newborn Safety Investigation (MNSI) investigation and one never event (wrong site nerve block). Committee queried the number of actions in respect of the Baby Cooling incident and received assurance that these were wider learning points and would not have affected the outcome. • Ten Patient Safety Incident Review (PSIR), eight Learning Reviews (LR) had been commissioned in September. • There had been a steady increase in incidents reported on InPhase, which was felt to be positive. • Zero Pressure Ulcers with lapses in care reported in September. • Falls – reduction in month and per thousand bed days. No new emerging themes following learning reviews. Continued monitoring. • PSIRF activity for September noted in appendices and assurances provided that an Invasive Procedures Group established to review theatre processes and checks. A report on the work of this group to be presented at a future Committee to provide assurance on the actions to prevent future never events in theatres. • The November Patient Safety Council assurance report was noted. There were no alerts to the Quality Committee.	Assurance
Infection Prevention and Control Quarterly Report – Q2	• All Healthcare Associated Infections (HCAIs) are above NHSE threshold levels. • One Healthcare associated MRSA bacteraemia case in Q2, two year to date (YTD). The second case reviewed in November considered avoidable due to incorrect antibiotic prophylaxis - an improvement plan is in development.	Assurance

	• Bloodstream Infection (BI) improvement plan in place including prompt sepsis screening, blood culture collection (77%) and administration of intravenous antibiotics (IV's) in one hour • Cannula spot check audits ongoing showing improvement over the quarter (87.5% in Sept) but remained below the Trust target (90%). • Aseptic Non Touch Technique (ANTT) month on month improvement with level 1 training above Trust target (86%) and level 2 below (81%). • Clostridioides difficile (C Diff) - MWL had remained below the Cheshire and Merseyside (C&M) rate for 12 months. • Klebsiella - 31 cases (to September), seven cases above threshold with organisational learning ongoing and review of Infection Prevention Learning Review (IPLR) process aligning to PSIRF process. • Infection, Prevention and Control (IPC) level 1 training e-compliance 94.3% September (target 85%). Focus for divisional teams against level 2 e-learning compliance for clinical staff (at 82.7%). • Following a period of increased cases of Pseudomonas aeruginosa Bacteraemia now returned to baseline with two cases in Q2. • Influenza cases low however noticeable increase in Covid-19 cases in September (Whiston, St Helens and Newton sites 152 cases, Southport and Ormskirk sites 76 cases). • 18 outbreaks in Q2 majority related to Covid-19, one Methicillin-Resistant Staphylococcus Aureus (MRSA) with robust processes to bring transmission under control. • 21 IPC policies aligned to date, one awaiting approval, three for approval in December.	
Maternity and Neonatal Services Reporting (Clinical Negligence Scheme for Trusts (CNST) Update).	• Committee received the quarterly maternity and neonatal performance report, including the maternity incentive scheme update.	Assurance
Freedom to Speak Up (FTSU) Report	• 91 concerns raised during Q1/Q2. Comparable increase against previous two years. 19 concerns (21%) raised anonymously supported through the Work in Confidence system. Focused work had taken place with selected divisions and staff groups to develop trust.	Assurance

	• Three cases of perceived detriment from reporting were noted, however no themes were identified reporting period no themes. One case remains under investigation. • 39 FTSU Champions now recruited across MWL, with eight newly appointed during 2025/26 to date. • Protected Characteristics in Q1 received information from seven members of staff and Q2 three staff members. • In Q3 active bystander training had been launched. • National Guardians Office is being abolished by HMG, and guidance is expected on how the residual functions will be allocated.	
Patient Experience Report (including Council Chair's report)	• Increase in Tendable audit completion. • 14/19 questions show improvement, 3/19 remained 100%, 2/19 deteriorated in month however scores show improving trajectory overall. • High scores observed across most areas in Antenatal Tendable audits with increase in service users surveyed. • Friends and Family Test (FFT) shows positive satisfaction rates with exceptions of Inpatients (slightly below target), Antenatal and Postnatal ward. Top themes noted. Limited comments received for Postnatal FFT. • Procurement of interpreter and translation services foreign language and non-spoken e.g. British Sign Language being undertaken. Evaluation begins December 2025. • NHSE New Experience of Care Framework - 88 standards for self-assessment by end February 2026 and regular reporting to Board from April 2026. This will be added to Quality Committee and Board work plans • National In-Patient Survey 2024 published in September. 8/9 whole section scores improved from 2023 survey. • National Maternity Survey 2024/25 – delayed publication until December 2025. • National Patient Experience Cancer Survey- positive 47% response rate. Trust performed strongly with three priority areas of improvement with an action plan developed.	

	• Neonatal Care Experience Survey 2025 - new national survey shortly to be conducted. • Patient Advise and Liaison Service (PALs) continue to focus on early informal intervention for patient concerns. • Positive progress and outcomes noted out of the NHS Patient Portal project. • National In-Patient Survey 2024 improvement plan to be strengthened to provide further assurances against actions 1and 2 which are aligned to the patient portal. Detailed update on the impact of the patient portal to be presented at the January Committee. The September and October Patient Experience Council assurance reports were noted. There were no alerts to the Quality Committee.	
Mandatory Training Compliance Report	• Core performance compliant (Sept 89.4%) • Compulsory performance compliant (88.2%) • Divisions, staff groups and training subjects below threshold to be supported to improve position with action plans presented. • NHS Standardised Core Mandatory Training Matrix in final stages of implementation. • Mandatory Training Learning and Oversight Group inaugural meeting held in September 2025. Forthcoming implementation of All Staff Competency Framework planned for April 2026. • Revised Training Needs Analysis (TNA) agreed for Safeguarding Training level 3.	
Alerts:		
• None		
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**	26 November 2025
Agenda Item	**TB25/088 (8.5)**		
Committee being reported	Strategic People Committee		
Date of Meeting	19 November 2025		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Workforce Dashboard	Mandatory Training - the Trust continues to exceed its mandatory training target, achieving 89.7% compliance in October, above the 85% threshold. Appraisals - appraisal compliance in October is at 89.7% reflecting strong engagement. Sickness Absence - overall sickness rose from 6.9% in September to 7.3% in October, with increases in Qualified Nursing & Midwifery (7.6% to 7.7%), Medical (2.8% to 3.2%), and Allied Health Professionals (AHP) (4.2% to 5.2%). Immediate actions being taken to address sickness include Winter Wellbeing campaign; targeted support for top 20% high-sickness areas; manager training on attendance conversations. The Committee will continue to monitor sickness trends and oversee the improvement programme. Vacancy rate - the Trust's overall vacancy rate remains favourable at 6.8%, below the 8% target. Most staff groups are within thresholds, though Health Care Assistants (HCAs) remain high at 15.8% which equates to a vacancy gap of 217.61 whole time equivalent (WTE) of which the Trust has a pipeline of 57.33 WTE. Nursing colleagues are currently reviewing nursing establishments therefore the residual vacancies are paused until the establishment reviews are concluded. Time to Hire (T2H) - Time to Hire continues to improve while above the 40-day target has reduced to 64.7 days from September's T2H of 66.7 day. People Performance Council continues to monitor the improve plan. Turnover - turnover remains stable and below target:	Assurance

	• In-month turnover: 0.7% (target: 1.1%) • 12-month rolling turnover: 10.6% (target: 13.2%) Health Work and Wellbeing (HWWB) - Pre-Placement Questionnaires - the total number received to cleared KPI average days: 3.5 days. The did not attend (DNA) rate for appointments has improved in month reducing from 10% in September to 9.5% in October.	

Workforce Operational Planning	Update on the five-year planning approach. Weekly meetings are in place to ensure data-driven decisions aligned with finance, operational changes, patient needs, and workforce assumptions.
	
	Key Assumptions:
	• **Year 1:**
	  • Known and predicted starters/leavers
	  • Planned workforce changes
	  • 1% reduction in bank/agency WTE (sickness)
	  • 12% reduction in bank (less 1% sickness)
	  • 30% reduction in agency (less 1% sickness)
	• **Year 2:**
	  • Predicted starters/leavers (based on 26–27 data)
	  • 1% reduction in bank/agency WTE (sickness)
	  • 12% reduction in bank (less 1% sickness)
	  • 25% reduction in agency
	• **Year 3:**
	  • Same approach as Year 2
	
	Planning is aligned with national guidance and regional expectations. Progress will be monitored through weekly reviews.
		Assurance

PricewaterhouseCoopers International Limited PwC Grip and Control Action Plan (Q2)	The committee received an update aligned to NHS England (NHSE) Provider Workforce Returns (PWR) along with the PwC grip and control action plan. Summary of performance: • Total Workforce: 120.2 WTE below plan (-1.1%) vs planned reduction of -383.39 WTE (-1%). • Substantive Workforce: +14.5 WTE above plan (+0.2%) due to successful recruitment and conversion of bank/agency staff. • Bank Usage: 89.7 WTE below plan (-10.8%) vs target -27%, reflecting strong controls and recruitment impact. • Agency Usage: 44.9 WTE below plan (-32.9%) vs target -39%, driven by tighter controls and conversion of high-cost roles. • By Staff Group:	Assurance

	• Infrastructure: -31.5 WTE (-1.3%) • Support to Clinical: -165 WTE (-6.6%) • Nursing & Midwifery: +49.5 WTE (+1.5%) • Medical & Dental: +35.9 WTE (+2.8%) • Overtime: Down 3.9 WTE in Q2 and 102.5 WTE YTD, reinforcing cost control. Reductions in bank, agency, and overtime combined with targeted growth in clinical roles demonstrate effective planning. However, achieving the planned reduction remains challenging.	
Sexual Safety Charter Update	The Committee received a report regarding the sexual safety framework has been updated to strengthen safeguards for patients and staff. NHSE wrote to Trusts on 20 August 2025 requesting further actions under the Violence Prevention and Reduction Programme to embed a culture of safety. Key Requirements for Trusts and Integrated Care Boards (ICBs): • Complete self-assessment against the updated framework. • Promote e-learning on sexual misconduct and consider specialist training. • Review policies to ensure sharing of concerns, investigation findings, Disclosure and Barring Service (DBS) information, and cumulative behaviour patterns with future employers. • Apply a patient safety lens alongside HR processes. • Ensure Electronic Staff Records (ESR) and IAT processes capture ongoing investigations during onboarding. • Review chaperoning policies for empowerment and auditability. • Engage Electronic Patient Records (EPR) suppliers to monitor unusual access to patient records. An action plan is in place and progress is on track.	Assurance
10 Point Plan to Improve the Working Lives of Resident Doctors	The Committee received a report relating to the 10 Point Plan to improve the working lives of resident doctors. In September 2025, NHSE requested all Trusts to complete a self-assessment against the criteria outlined a the 10-Point Plan to Improve Resident Doctors' Working Lives. The report outlined the actions being taken by the Trust, both as a host organisation and as the Lead Employer for c.14,000 colleagues in training and to the Trusts Payroll clients to date. The key focus of plan includes the following areas	Assurance

	with the aim of improving the working lives of Resident Doctors and covers the following commitments: 1. Workplace Wellbeing 2. Rota and Schedule Transparency 3. Annual Leave Reform 4. Board-level leadership 5. Payroll Accuracy 6. Eliminating Mandatory Training Duplication 7. Exception Reporting 8. Course-Related Expenses Reimbursement 9. Rotation Reform 10. Lead Employer Model Expansion From October 2025 NHS England started to publish Trust level data on the following indicators as part of the NHS Oversight Framework and Chief Medical Officers, Directors of Medical Education, and Heads of Medical Education received the Trust's score of 67% against the framework. Good progress has been made to data against an action plan approved by the Executive Committee which will be monitored via the People Performance Council and the HR Commercial Services Council. Both the Chief People Officer and Chief Medical Officer have been identified as the Senior Leads for Resident Doctor Experience (SLRDE).	
Education Experience Survey Action Plan Updates	The Committee received feedback from the 2025 General Medical Council (GMC) National Training Survey (NTS) which is the first survey conducted for MWL. The response rate was 84% (Whiston 90%, Southport 70% and Ormskirk 63%) Data analysis of the report has been completed by the Directors of Medical Education, Foundation Programme Directors, Trust Speciality Training Leads and the Assistant Director of Clinical & Medical Education. The update also included the action taken to address the feedback shared in the 2024 GMC NTS across legacy sites. Across MWL, 17 of 18 indicators are within national benchmarks for 2025. Formal concerns have been raised by NHSE & GMC in 10 specialty groups at Southport. NHSE plans a quality intervention in response. Actions planned and taken include: • Response letter submitted to NHSE (14/11/2025). • Meeting held with Chief Executive, Chief People Officer, and Chief Medical Officer to agree action plan. • GMC survey reports presented to Executive Committee	Assurance

	and SPC. • Action plans developed with Directors of Medical Education, Specialty Training Leads, Clinical Directors, and Divisional Managers. • Listening events scheduled for January 2026 at Southport, led by Director of Medical Education.	
EDI High Impact Actions Update	The paper provided assurance regarding the NHS EDI Improvement Plan and six High Impact Actions (HIAs) to tackle prejudice and discrimination, aligned with MWL's People Strategy 2025–28 and regional commitments.	Assurance
Assurance Reports from Subgroup(s)	It was noted that the following policies have been approved by the People Performance Council: • Health Professional Alert Notice Procedure (HPAN) • MWL Grievance Policy & Procedure • Reference Policy	Assurance
SPC Annual Workplan 2025/26	The following changes to the SPC Annual Workplan were noted: • An assurance update on the Trust's delivery of the 10 Point plan to Improve the Working Lives of Resident Doctors with detailed action plans for the Trust and Lead Employer will be monitored respectively by the People Performance Council and the HR Commercial Services Council • The addition of the new Equality, Diversity and Inclusion Council • The delegation of assurance for the four people plan pillars to the respective Councils. • The addition of the Workforce PwC Grip and Control Action Plan	Assurance
Any Other Business	None	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board Meeting**	**Date**	26 November 2025
Agenda Item	**TB25/088 (8.6)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	20 November 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Chief Finance Officer (CFO) Update	• National Cost Collection Index (NCCI) published – MWL 97%; had points of delivery (PODs) ranging from 85% - 106%. • Productivity packs been published – discuss the nine domains. • Productivity measure being released on a monthly basis from NHS England (NHSE) – MWL 1.8%; Cheshire and Merseyside (C&M) 1.7% and national position at 2.3%. MWL better than last year. • First wave of Foundation Trusts (FTs) announced – Alder Hey in C&M • North West (NW) financial position as at M6 was discussed. Region is off plan. • C&M only system in NW having deficit support funding (DSF) being withheld. • Discussion around financial undertakings which have been issued to various organisations within the system.	Assurance
Committee Performance Report Month 7 2025/26	• Accident and Emergency (A&E) performance declined to 71.6% in October, below the national at 74.1%, but ahead of C&M at 71.9%. • Long waits in emergency department (ED) a challenge – 19.1% waited over 12 hours in October. This was an increase from the previous month. • Handover 45 – a decline in performance to 82.2% of patients arriving by ambulance being handed over within 45 minutes. • No Criteria to Reside (NC2R) patients was at 22.2% • 18 Week performance in September was 63.9%.	Assurance

	• The Trust had 1,562 52-week waiters at the end of October; seven 65-week waiters and five 78-week waiters. • Diagnostic 6-week performance for October was 94.1% which remained ahead of both national performance at 77.5% and C&M performance at 87.6%. The target remains at 95%. • Cancer performance in October improved again to 65.8% for the 28-day standard (target 77%). Slight decline in performance for the 62-day standard at 76% (target 85%). • Bed occupancy averaged 97.9%	
Finance report Month 7	• The approved MWL financial plan for 25/26 is a deficit of £10.7m. This is a £41m deficit excluding the deficit support funding. • The plan includes £35m of system led strategic opportunities/cost reductions to be realised or reallocated by C&M during 2025/26. • The Trust is reporting a M7 deficit of £38.2m (excluding deficit support funding) which demonstrated an improved run rate and £4.6m better than plan. • Income assumes all variable activity and the Southport Community Diagnostic Centre (CDC) being funded by commissioners. Contracts are not yet finalised, and negotiations continue. • The Trust's combined 2025/26 Cost Improvement Programme (CIP) target is £48.2m. In M7, the target has been exceeded with £28.5m delivered to date, £1.9m above plan. • At M7 agency costs equate to £8.8m (2.3% of total pay costs). • The Trust had a closing cash balance of £1.7m. The Trust's Provider Revenue Support application for £8m in November was declined. • Aged debt has increased slightly (debt greater than 90 days at £13.4m in October compared to £13.3m in September). • The capital plan for the year totals £64.6m which includes PFI Lifecycle and IFRS16 Lease Remeasurement. Year to date (YTD) spend is below plan however there are plans in place to ensure no slippage by year end.	Assurance

M7 Forecast	• Current plan less deficit support stands at £40.9m deficit • Current run rate would give a £67.6m deficit, therefore improvement required of £26.7m. • Current forecast is a (£6.8m) variance to plan excluding deficit support funding - this includes non-recurrent mitigations • Delivery of the forecast depends on significant internal workstreams realising the savings such as bank and agency reductions, plus maintaining the reduction on overtime across the Trust. • Conversations with commissioners ongoing regarding non-payment for activity undertaken. • CDC contractual issue has now been agreed. • Continue to improve the position as we work to ensure the organisation meets the financial plan. • Discussion regarding what PricewaterhouseCoopers International Limited (PwC) reviews have focused on recently – the monthly improvements and how we have performed against what we forecast the previous month, plus headcount reductions. In M7, delivered £0.7m better than forecast.	Assurance
Cash Update	• Key risks to cash remain deficit funding being withdrawn and delivery of Income and Expense (I&E) forecast • Two Provider Revenue Support cash applications have so far been approved at £10.9m and £11m • The application for further £8m cash support in November has been declined. • Low risk cash mitigations are being implemented such as ensuring supplier payments are not early and ensuring debt is paid to ensure we can meet financial obligations within November and December. • MWL have been exploring options with the regional NHSE team. • The current cash position is in line with plans submitted to NHS England and the start of the financial year. • Trust Lead Employer arrangements are not factored in to the current cash regime. This is being picked up with NHSE.	Assurance

Month 7 2025/26 CIP Programme Update Women & Children's (W&C) Division	• Total Trust efficiency target for 2025/26 is £48.2m recurrently, which equates to 5% for all departments. • At M7, 177 schemes have been delivered with a further 95 schemes at finalisation stage. Current delivered/low risk schemes have a value of £56.7m in year equating to 118% of the target and £45.6m recurrently, 95% of the target. • W&C Division update outlined the overdelivered CIP position for 2025/26, with a focus on recurrent CIP delivery. Planning for 2026/27 is underway.	Assurance
Review of Difficult Decisions	• Committee discussed current difficult decisions that have already been made and reflected further discussion would be needed at Board to meet the current £6.8m gap to the financial plan. • MWL to show options have been considered alongside safety and patient quality risks.	Assurance
HR Commercial Services Financial Performance Report	• Covers payroll services and lead employer • On plan to deliver the financial plan, including CIP. • Additional trainees this year – recharging 42 organisations a total of £60m per month. • Lead Employer – continue to automate processes to ensure efficient and can re-organise their structures • Payroll – four additional clients this year and continue to have enquiries from organisations. • Manage aged debt by engaging with clients. Some escalation with NHS England.	
Planning 2026-27 – 2030-31	• Planned approach to the Trust submitting a 3-year plan in December 2025 and the 2026/27 plan in March 2026. • Technical Finance guidance, updates and templates have been published this week. • Summarised the latest information relating to NHS Planning, including objectives and board assurance requirements • High level initial figures for finance and workforce were discussed, alongside all the metrics MWL will be expected to meet for activity. • NHSE have published control totals for individual organisations.	Assurance

	• Capital allocations were discussed; a number of funds have been set aside in the NW that Trusts can bid for aligned to NHS strategic goals. • Productivity packs have been published by the national team which will be used to support planning delivery.	
Diagnostics Targets Review	• An overview of the current performance and trends with a comparison to other system providers. • There has been increased activity across many of the main modality tests. • Significant reduction in 6- and 13-week breaches.	Assurance
Assurance Reports from Subgroups:	• CIP Council Update • Capital Planning Council • Estates & Facilities Management Council Update • IM&T Council update	Assurance
Alerts		
None		
Decisions and Recommendation(s):		
The Board is asked to note the report.		

Title of Meeting	**Trust Board**		**Date**	26 November 2025
Agenda Item	**TB25/089**			
Report Title	Trust Objectives 2025/26 – Mid Year Review of Progress			
Executive Lead	Rob Cooper, Chief Executive			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To Approve**	X	**To Note**

Purpose

To assure the Board of the progress being made in delivering the 2025/26 Trust Objectives.

Executive Summary

1. The Executive leads have reviewed progress at the end of quarter 2 in delivering the 2025/26 Trust Objectives, and rated them against the following criteria –

	Objective fully delivered at end of Q2 or with high confidence of full delivery by 31 March 2026
	Objective progressing as planned and on track to be fully delivered by 31 March 2026
	Objective behind plan and at risk of not being delivered by 31 March 2026

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

3. There were 28 objectives approved in March 2025, each supported by measures of success. One objective (4.3) has now been superseded by the Ambient Voice Technology (AVT) opportunity, which leaves 27 live objectives.

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

Objective fully delivered at end of Q2 or with high confidence of full delivery by 31 March 2026	7
Objective progressing as planned and on track to be fully delivered by 31 March 2026	19
Objective behind plan and at risk of not being delivered by 31 March 2026	1

5. At this mid-point of the year there is one objective where the lead Director does not have confidence in delivery by the end of the financial year. The Trust is working with the Integrated Care Board (ICB), NHS England (NHSE) and PricewaterhouseCoopers International Limited (PwC) to achieve the 2025/26 financial plan.

Financial Implications

Included in 2025/26 budgets	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board are asked to note the mid-year assessment of the Trust objectives for 2025/26.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Appendix 1

Mersey and West Lancashire Teaching Hospitals NHS Trust

2025/26 Trust Objectives – Mid-year Progress Review

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**					
1.1	Improve measurable success in areas where our patients told us we didn't get it right first time including inpatient areas, ED, maternity with a focus on antenatal.	CNO	• Improvement against previous year's national survey results in relation to: ○ Management of pain ○ Kindness and compassion whilst in hospital ○ Experience of waiting time information • As a minimum, conduct quarterly local surveys based on national survey indicators • Maintain and embed the patient experience score from 5* Ward Accreditation Programme	Quality Committee	• 2024 National inpatient survey results published by CQC. Improved scores for Kindness (8.8) and Management of Pain (8.7). • Experience of waiting for beds in ED actions in place and included in the improvement plan for the 2024 National Urgent and Emergency Care survey, covering: - Communication - Nurse establishment review to include escalation requirements. - Triage nursing staff advising patients what to do if further help is required whilst waiting for a bed/treatment. - Corridor Care audits completed each month. - Volunteer recruitment to support patients experiencing extended stays in ED. • Monthly local patient surveys aligned to the National Survey improvement plan for Inpatients, ED and Antenatal areas. Results reported to Quality Committee. Scores consistently >90%. • Ward 5*accreditation patient experience questions updated to reflect feedback from patients, families/carers and the national survey results, to focus on the areas that scores lower. On Q2 the patient experience indicators have scored 92.2%
1.2	Ensure improvement and sustainability of nutritional standards for patients.	CNO	• Achieve 95% of adult inpatients screened for malnutrition on admission using the MUST tool	Quality Committee	• Work on-going to enhance data collection from careflow vitals/connect to support monitoring of the KPI. This will be in place during Q3.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
			• Achieve 95% of patients with a score of 2 or more who receive an appropriate care plan • Improve the processes to ensure 95% of high-risk patients are referred to a dietician • Achieve and maintain 90% for nutrition score consistently across all wards for the 5* Ward Accreditation Programme		• There is now consistency of inpatient screening for MUST risk assessment within 24 hours. September performance was 90% (NCI data) • NCI date shows a deterioration in care planning and dietetic referrals to 86%. • In the Trust 5* Accreditation Programme, the Nutrition and Hydration standard is assessed for all inpatient areas on a rolling programme. The average score across the Trust is 91%. • Performance and good practice from shared at the Matron and Ward Manager meetings, Nutrition and Hydration Steering Group and features in Quality and Safety walkabouts. • Introduction of adaptive cutlery at Southport and Ormskirk sites (already in place on other sites).
1.3	Improve measurable success for people that birth have told us we didn't get it right first time who access antenatal services	CNO	• Improvement against previous year's national survey results via quarterly surveys	Quality Committee	• Local antenatal surveys, based on the National Maternity Survey questions have reported satisfaction levels of >90%), in Q1 and Q2, which is an improvement on the last survey data. • Actions plan following the last National Maternity Survey on track for delivery by the agreed deadline
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**					
2.1	Continue to ensure the timely and effective assessment and care of patients in the Emergency Department.	CNO	• Achieve 95% of appropriate patients triaged in the emergency departments in line with the national standard of triage within 15 mins • NEWS – 80% of observations completed on time or within tolerance • All patients with a working diagnosis of sepsis receive antibiotics in line with the NICE guidance	Quality Committee	• Triage of patients within 15mins 79% for Q2 (Q1 64%). Whiston Hospital subject to a quality improvement project., during Q1. • Average time to triage in September was 9 mins for Whiston and 10 mins for Southport. Southport will undertake quality improvement following completion of current ED capital scheme to enlarge the waiting room/create a new entrance • NEWS 66% compliance for Q2 (57% at Q1). Improvement actions continue. • Sepsis at 75% compliance. Accuracy of recording being audited and quality improvement project commenced in Q3.

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Mid-year review and RAG</th></tr>
<tr><td>2.2</td><td>Improve the Trust's compliance with IPC standards.</td><td>CNO</td><td>• Eliminate methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia infections as a result of lapses of care

• Implement action to reduce avoidable hospital onset MSSA bacteraemia

• Achieve minimum aseptic non-touch technique (ANTT) compliance of 85% for Level 2 across MWL (practical)

• 90% compliance with visual infusion phlebitis (VIP) monitoring

• Achieve 90% for the IPC and indwelling devices standard for the 5* Ward Accreditation programme</td><td>Quality Committee</td><td>• Two MRSA bacteraemia to date (6 previous year). Q1 case unavoidable. Q2 case considered avoidable due to incorrect antibiotic prophylaxis intraoperatively, and incomplete wound assessments. Learning shared.

<table><tr><th></th><th>Q3</th><th>Q4</th><th>Q1</th><th>Q2</th></tr><tr><td>MSSA BSI</td><td>26</td><td>20</td><td>18</td><td>20</td></tr><tr><td colspan="4">Target 10% Reduction</td><td></td></tr></table>
• In Q2 there was 20 cases of MSSA, with 38 YTD, which is a reduction of 7 cases compared to the same period in 2024/25.
• The Trust has been below the Cheshire & Merseyside rate for Q1 and Q2 (was higher in 2024/25).
• The Bloodstream Infection Improvement Plan remains in progress.
• Level 1 & 2 ANTT compliance continues to improve. Level 2 = 81% (target 85%). Monitoring undertaken at Divisional IPC meetings, DPRs and Quality Committee.
• VIP compliance target not yet achieved. Improvement actions focused on cannula care, and this is the priority area for November quality walk rounds.
<table><tr><th>VIP Target</th><th>Q3</th><th>Q4</th><th>Q1</th><th>Q2</th></tr><tr><td>90%</td><td>85.2%</td><td>77.1%</td><td>84.8%</td><td>80.2%</td></tr></table>
• 5* ward accreditation score for IPC was 91% for Q2. Indwelling devices score was 75%.</td></tr>
<tr><td colspan="6">3. 5 STAR PATIENT CARE – Pathways</td></tr>
</table>

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient					
3.1	Continue to improve the effectiveness of the discharge process for patients and carers.	COO	• Achievement of 20% target for patients discharged before noon by March 2026 • 10% improvement in discharges by 6pm and 8pm during the week against 2024/25 position • 10% reduction in the number of patient bed moves after 9pm (core wards) against 2024/25 position • 10% improved utilisation of the discharge/transfer lounges against the 2024/25 position. • Improve average discharge prescription dispensing turnaround time by 10 mins (from 92 to 82 mins) by March 2026 to below the national average • Reduce average take home prescription arrival time to pharmacy by 60 minutes.	Finance & Performance Committee	• Rate of discharge before noon currently 18% • 1% improvement to date in discharges by 6pm during the week • 0.84% improvement to date in discharges by 8pm during the week • YTD no reduction in the number of bed moves after 9pm • 5% improvement in utilisation of discharge/ transfer lounges against the 2024/25 position • Improvement actions continue to be refined to achieve the above • Discharge prescription turnaround times average now 86.7minutes. Southport and Ormskirk sites are maintaining compliance. Whiston and St. Helens sites - 15 minute improvement since M1. Pilot of “soft” cut off times is expected to deliver the target of 82 minutes Trust wide by March 26. • The reduction in take home prescription arrival time to pharmacy has been achieved across sites (noting different data flows on sites). Southport and Ormskirk sites at M7 have reduced by 215 minutes to 232 minutes. Whiston and St Helens sites have reduced by 17 minutes to 52 minutes.
3.2	Implement standardised clinical pathways across MWL.	CMO	• Implement a unified clinical leadership structure for all specialties • Implement single clinical pathways for key conditions including sepsis and #NOF • Reduction in unwarranted variation of clinical outcomes across sites • Implement Trust professional standards for inter speciality referral in the ED and	Quality Committee	• Appointments now made to cross-site Deputy Divisional Medical Director roles in Medicine and UEC and Surgery Divisions to strengthen leadership and alignment of clinical standards and pathways across sites. • Associate Medical Directors for Patient Safety appointed to lead targeted improvement programmes including sepsis management and learning from deaths, to address unwarranted variation in patient outcomes. • The Clinical Director structure has been agreed in principle and recruitment due to commence with the new CMO. This will deliver unified leadership across specialties and provide a

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
			audit performance against the agreed standards.		framework for the continued alignment of clinical pathways and standards of care.
3.3	Improve cancer pathways to deliver the national cancer performance cancer standards	COO	• 80% of patients to receive diagnosis or ruling out of cancer within 28 days of referral by March 2026.	Finance and Performance Committee	In August 2025 (M5) 64.2% of patients are receiving a diagnosis or ruling out of cancer within 28 days of referral. Improvement actions focused on 3 x tumour sites, skin, lower GI and breast, with trajectory to achieve 80% Due to the lag time in reporting cancer performance, 4 key internal improvement metrics have been set as lead indicators of progress. • Median wait for photo clinic – 18.2 days to 4.7 days. • Median wait for an outpatient appointment – 32.6 days to 15.8 days • % Straight to Test (STT) – 38.3% to 48.5% • Average triage time – 7.7 days to 0.4 days • Cancer backlog – 285 to 161
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**					
4.1	Enhance internal communication efficiency.	DoI	• Enable Switchboard to work as a single team via harmonisation of the telephone operating system. • Reduce administration burden on clinicians by piloting and evaluating an AI tool in patient consultations to support real-time documentation, automate order placement within the EPR (Electronic Patient Record), and reduce administrative burden on clinicians.	Finance & Performance Committee	• A consistent telephony platform (NetCall) is now live across all MWL sites. This provides the technical foundation required for a single-team Switchboard operating model • An Ambient Voice Technology (AVT) pilot to commence in Q3 with a small number of specialities. Different products being evaluated and a business case and options appraisal will be produced to determine adoption at scale.
4.2	Improve patient communication and engagement.	DoI	• Improve patient support and reduce missed appointments by expanding digital waiting list management solutions across all sites.	Finance & Performance Committee	• Digital Waiting List validation is embedded at the Southport & Ormskirk sites, with 1,753 patients' self-removed during 24/25. System to be implemented for the St Helens and Whiston waiting lists in November 2025.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
			• Pilot and evaluate an AI-driven Did Not Attend (DNA) or Was Not Brought (WNB) prediction tool. • Enable patients to view their outpatient letters on the NHS App through implementation of Phase 1 of the Patient Engagement Portal (PEP).		• Proposals for an AI-driven Did Not Attend / Was Not Brought prediction solution in development with the supplier (Netcall). Proposed solution to be reviewed by senior ops leads in charge of DNAs / GIRFT in November with an estimated pilot go-live for March 26. • The Patient Engagement Portal is now live at Southport & Ormskirk, enabling outpatient letters to be viewed via the NHS App and directly via the PEP for non-NHS App users.
4.3	Implement a new speech recognition system to improve the turnaround times for clinic letters.	DoI/ CMO	• Implement the new system and train staff in its use to consistently achieve a 48-hour (working week) turnaround for urgent letters and 7 days for routine letters	Finance & Performance Committee	• This objective has been superseded by the Ambient Voice Technology programme referenced under Objective 4.1.
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**					
5.1	Drive Digital System Convergence and Integration to ensure collaborative working across MWL.	DoI	• Launch the single EPR re-procurement process, ensuring alignment of clinical and operational processes across legacy systems. • Deploy a single maternity information system (BadgerNet) across MWL • Deploy Electronic Prescribing and Medicines Administration (EPMA) system at the Southport & Ormskirk Hospitals sites	Finance & Performance Committee	• EPR procurement continues in partnership with WHH NHSFT. Due to procurement technical requirements, pre-market engagement is being re-run in Q3 2025/26. NHSE investment agreement has been submitted to enable readiness, including standardisation and process mapping. • BadgerNet deployment focusing on completion of future state clinical pathway agreement across maternity service. • EPMA build and system testing continue with go-live planned for early 2026.
5.2	Continue to embed service improvement techniques and the culture of improvement across MWL	DoS	• Complete the cascade of training of staff in the MWL service improvement methodology • Embed the consistent approach to service improvement and transformation.	Executive Committee	• Service Improvement Strategy drafted • Service improvement methodology for MWL selected and training roll out in progress • Service Transformation and Improvement Council established
6. DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.					

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
6.1	Develop and embed a culture that empowers individuals to lead healthy lives and thrive at work by providing holistic wellbeing support.	CPO	• Develop a communications and engagement strategy to support and champion a cultural shift around flexible working and improve performance against the national average for 'We work flexibly' in the national staff survey.	Strategic People Committee	• Culture and engagement calendar of events agreed at Strategic People Committee in May 2025, and a digital calendar on the staff intranet (in the top 5 most visited intranet pages). • Summer Wellbeing Week 28th July- 1st August took place with a presence at 4 sites (Southport, St Helens, Ormskirk and Whiston) – flexible working was the focus. A series of virtual sessions also delivered with an average attendance of 20 staff. • MWL People Week focused on promoting flexible working opportunities, health and wellbeing and staff benefits. • Pilot of unlimited roster requests commenced in Maternity at Whiston- Ward 2E and Delivery Suite, from 20th October roster period – positive staff feedback to date. • Divisional engagement plans developed in response to Staff Survey feedback – included flexible working action plans, engagement and trial options for flexible working requests.
6.2	Create an environment where all staff feel supported, valued, and able to perform at their best.	CPO	• Complete the harmonisation of all workforce policies across MWL • Ensure that all divisions are demonstrating adherence to the attendance management policy by proactively reviewing and managing absences in compliance with policy.	Strategic People Committee	• Six policies approved YTD. • 17 further policies are in ongoing negotiation with staff side. • Divisional People Meetings each month to monitor sickness absence trends and drive compliance with the attendance management policy. • Completion of welcome back conversations is a divisional performance metric. • Workforce FIG, PPC and SPC all focus on sickness absence. • Action plan in progress to support staff with absence due to Stress/Anxiety/Depression and MSK.
6.3	Foster a workplace that champions equity, diversity, and inclusion to create a culture of	CPO	• Improvement in the national staff survey theme "We are compassionate and inclusive"	Strategic People Committee	• EDI Training programme 2025-2026 launched • Civility, Respect and Trust values embedded into all Leadership and Management Training.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
	belonging, respect, and opportunity for all.		• Improvement in the national staff survey theme "We each have a voice that counts"		• Mapping of MWL Leadership and Management Development offer against the draft NHSE Leadership and Management Framework completed. • Launch of new 'Warm Welcome' induction programme • Anti-Racism statement approved. • Anti-Racism Launch events August – October. • Bronze anti-racism accreditation evidence submitted against the NW Anti-Racism Framework • Schedule of Team Talks developed in line with priority areas identified from the Staff Survey. Well attended and feedback being used to identify any themes. • New FTSU champions recruited • Focus on Staff Survey 'You Said, We Did' communications in readiness for 2025 survey.
6.4	Strengthen core management and leadership skills within our workforce to ensure our leaders are equipped with the required skills and techniques.	COO	• Create a common set of tools and techniques for all operational managers in year 1	Strategic People Committee	• Developed 'hub and spoke" management development offer which combines face to face and virtual 'bite size' sessions. • Clinical Director Leadership Programme, sessions updated to include Finance and HR • 43 CDs enrolled on the programme, with 5 completing all modules to date. • Developed and implemented Operational Manager development programme. • In Q1 & Q2 500 staff have accessed these learning opportunities • Draft competency framework under consultation and due to be launched Q3 2025/26 and rolled out Q4 2025/26 into Q1 2026/27
7. OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**					
7.1	Deliver 2025/26 elective/outpatient recovery targets	COO	• Deliver 5% improvement from 2024/25 position in referral to treatment (elective/day case and outpatients) targets for consultant led services	Finance & Performance Committee	• In September Trust reported 64.2% of patients treated within 18 weeks, against a plan of 63.7%. The baseline performance (November 2024) was 58.7%.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
			• 1% reduction in 52 weeks + waiters		• In September 2025 MWL reported 1,224 52+ week waiters (1,657 in March) a 26% reduction. • In September 2.3% of patients on the waiting list had waited over 52 weeks, against the target of 1% by March 2026.
7.2	Deliver the NHS urgent and emergency care performance standards/targets	COO	• Improve A&E waiting times so that no less than 78% of patient are seen within 4 hours by March 2026 • Achieve 30 minute average ambulance handover target	Finance & Performance Committee	• 4 hours performance has been above 78% every month YTD, with September 2025 at 78.4%. • In September 72.2% of ambulance arrivals were handed over in 30 minutes and over 90% against the handover 45 target.
7.3	Deliver cancer improvement targets	COO	• 82% of patients treated within 62 days	Finance & Performance Committee	• In August 62 day performance was 81.7%. Improvement trajectories in place to achieve the 82% target by March 2026.
8. FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**					
8.1	Deliver the agreed financial plan including outturn, cash balances and capital resourcing limits.	CFO	• Achieve the approved financial plan for 2025/26 • Deliver the agreed Cost Improvement Programme • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme, to progress the strategic estates delivery plan, equipment replacement and IT investments	Finance & Performance Committee	• The Trust is currently forecasting an adverse variance to the plan. • The Trust has had the last 2 cash requests rejected; therefore, cash preservation measures will need to be enacted including potential reduction in the capital plan spend.
8.2	Work with partner organisations across the ICS to develop and deliver opportunities for collaboration at scale and increased efficiency.	CFO	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system • Drive forward other opportunities for collaboration with system partners e.g., payroll and Eastern Pathology Hub	Executive Committee	• Pathology Hub business case approved July and staff due to transfer to MWL on 01/04/26 • Continued payroll service growth with CoCH, MCT & WHH all transferring in 2025/26. • Other opportunities of efficiency at scale shared within ICS including: ○ Nursing Bank provision

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
					○ Single OH, and recruitment service. • Additional collaboration opportunities being included within 3-year plan, as part of medium-term planning.
8.3	Deliver the agreed capital schemes to deliver the capacity needed to meet service demand and a safe, high-quality environment for patients and staff.	DoCS	• Deliver the planned estates capital developments for 2025/26 to optimise capacity/space utilisation and improve patient experience • Deliver year three of the backlog maintenance reduction programme at Southport and Ormskirk Hospitals, including options for decant spaces where required • Deliver the planned PFI lifecycle programme for St Helens and Whiston Hospitals to maintain the quality of the environment	Finance & Performance Committee	• The capital programme was approved in July, and all approved schemes remain on track to be delivered by year end (subject to Building Safety Act approvals where required). • The backlog maintenance plan is progressing as planned, with additional funds secured from the national NHSE building safety fund, in year. Planned works in clinical areas remain dependant on access, which could be impacted by patient flow escalation. • Lifecycle programme progressing as planned, access remains the biggest risk to delivery for improvements in clinical areas.
9. STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**					
9.1	Deliver the key milestones of the Shaping Care Together Programme for 2025/26 in collaboration with ICB partners and NHS England.	CEO	• Achieve the 2025/26 milestones for the Shaping Care Together Programme – including approval of the Pre-Consultation Business Case and completing public consultation	Executive Committee	All milestones for the SCT programme have been achieved in line with the project plan. Most recently a 13 week public consultation concluded on 3rd October, following which, analysis of all data and feedback has commenced in preparation for development of the decision making business case, which is the next key stage in the programme.
9.2	Work with the ICS and each of the Place Based Partnerships within the MWL footprint to improve patient flow and increase timely discharge from hospital to appropriate community /social care settings or home-based support.	DoInt	• Urgent Care Recovery Programme – work with Places to improve the discharge from hospital process, principal measures include: - ○ Reducing patients who are non-criteria to reside to < 15%	Executive Committee	The non criteria to reside performance is not consistent. Whiston hospital was <15% in October and are amongst the strongest performers in C&M. Whereas @ 25% of patients. Work with Sefton and West Lancs LAs is ongoing to understand the issues and recover the performance.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year review and RAG
			○ Reducing the patients ready for discharge days in line with best practice		Discharge ready days are currently 10 days (14 days in April 2025)
9.3	Working with NHSE and the ICB to develop a long-term plan for financial and clinical sustainability for MWL	CEO	• Agree a three-year financial recovery plan • Develop strategic service reconfiguration options and delivery plans to support long term clinical sustainability	Executive Committee	Detailed financial plans in development for submission in line with national expectations 3-year recovery plan narrative produced and submitted to ICB/NHSE for consideration. Detailed plans to support service configuration also in development to support the Trust strategy, for review at October 2025 Trust Strategy Board.
9.4	Develop a Community Services strategy to support the improved effectiveness and outcomes for patients and staff.	DoS	• Implementation of a Community Services strategy including service outcome measures, leadership structure, digital solutions, reporting and estates requirements	Executive Committee	• National minimum data set for community services to be launched • Safe staffing methodology for community services also now available and being used in the latest nurse establishment review • Outcome of West Lancashire community services tenders not yet known
9.5	Co-ordinate the implementation of the Trust Health Inequalities Strategy and delivery plan	DoInt	• Develop the Health Inequalities dashboard to meet the requirements of the strategy and delivery plans • Work with system partners to create a shared Health Inequalities dashboard for the ICB which is shared on the CIPHA platform • Demonstrable Trust contribution and improvements in the delivery of Core20plus5 for Adults and Children and Young People • Continue to maximise the potential of the Trust as an anchor institution in our communities to improve health, education and employment.	Executive Committee	• The BI Health Inequalities dashboard is completed and will be launched in November 2025. This has developed from a MWL only tool, to a universal application for all C&M Acute Trusts and Places to use. • The Trust is playing a lead role in both Neighbourhood Health Wave 1 “Pioneer” Places (Sefton & St Helens) and will be supporting the delivery using case finding tools that address Core 20plus5 concept. • The Trust has led the development of a Health and Care Career Hub in St Helens, The Chief Executive has taken a place on the Liverpool CEO forum, and the Trust is represented on the Knowsley Chief Officer Group, all examples of our wider commitment to the growth of places and communities

Title of Meeting	**Trust Board**		**Date**	26 November 2025
Agenda Item	**TB25/090 (10.1)**			
Report Title	Maternity and Neonatal Services Quarter 2 2025/26 Update			
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 update and inform the Board regarding the priorities and progress of the Maternity and Neonatal services across Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL).

Executive Summary

A summary of the progress within Maternity and Neonatal services at MWL that includes:

- Perinatal Mortality
- Maternity and Newborn Safety Investigation (MNSI) update
- Neonatal Medication incidents
- Saving Babies Lives (SBLv3) Continuous improvement and working towards full compliance supported and monitored by the Local Maternity and Neonatal System (LMNS)
- Antenatal and Newborn (ANNB) ANNB Screening Quality Assurance (QA) Visit
- Complaints, Claims and patient experience
- Maternity Red flags
- Neonatal suspension of services
- Workforce
- Update on the progress of the Three-Year Delivery Plan

Financial Implications

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

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Maternity and Neonatal Services Quarter 2 2025/26 Update

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance

	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Maternity and Neonatal Quarter 2 2025/26 Update

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

1. Maternity Incentive Scheme (MIS)

The Maternity Incentive Scheme (MIS) Year 7 was released in April 2025, and work is ongoing to collect the required evidence for submission.

To be eligible for payment under the scheme, the Maternity Service is required to be compliant with all 10 safety actions and if assured, to submit a completed Board declaration form to NHS Resolution by 12 noon on 3 March 2026. The Trust CEO must ensure that the Accountable Officer (AO) for the Integrated Care System (ICB) is appraised of the MIS safety actions evidence and the declaration form and that they are both required to sign the declaration form to confirm they are both fully assured and in agreement with the compliance submission.

A CNST update paper with further details of the evidence submission and compliance to date has been completed and will be presented to the Committee. The report details current progress and evidence demonstrating assurance and highlights that:

- SA2 and SA6 have evidence of full compliance.
- Safety actions 3,4,5,7,8,9 and 10 are currently compliant or on track for full compliance after the 30th of November 2025.
- SA3: The implementation of a transitional care service fully aligned to the BAPM framework has been further delayed due to challenges in recruitment, retention, sickness and unavailability of staff. An updated TC action plan has been developed with revised clear timescales which requires submission to the Board and the neonatal ODN to establish compliance. The updated action plan is included in Appendix 1
- SA 4: neonatal nursing workforce. The neonatal unit on the Whiston site has identified a deficit of 3.45WTE registered nurses based on activity levels following completion of the Q2 workforce calculator tool. An action plan has been developed which details the requirement to review the nursing establishment, undertake a business case and review the current neonatal cot configuration. The action plan will be presented to the Trust Board, ODN and LMNS in November 2025 and will be monitored via the risk register to enable declaration of compliance and is included in Appendix 2

The is one area of concern relates to:

- SA1: Standard c) is currently non-compliant. To date there have been 12 cases that required a PMRT review started within 2 months of the death. The technical guidance states that as an absolute minimum, all 10 of the ‘factual’ questions in the PMRT tool must be completed for the review to be regarded as started. Although all 12 were started within the required time period, a documentation error occurred resulting in 1 case, only completing 9/10 questions. The current compliance rate is below the 95% requirement at 91.7%. In order to obtain 95% compliance, the service would need 20 cases within the reporting period with 19/20 needing to be compliant by the end of the reporting period of 30th November 2025.

The Local Maternity and Neonatal System (LMNS) were provided with evidence in relation to safety actions 3, 4, 5, 6, 7, 8 and 9 via quarterly engagement assurance meetings and the provision of evidence onto the Futures platform for review.
Safety actions 1, 2 and 10 were not reviewed by the LMNS as this was not within their remit as triangulation of compliance will be undertaken by NHSR in conjunction with other sources such as MBRRACE and MNSI.

The main area of concern is Safety Action 1, standard c, which is currently non-compliant. Out of 12 cases requiring a PMRT review started within two months of a death, one case had incomplete documentation (9/10 factual questions completed), resulting in a 91.7% compliance rate, below the required 95%. To achieve compliance, 20 cases are needed in total, with at least 19 compliant by 30 November 2025.

The MIS year 7 update is included as a separate report (agenda item 10.2). The report includes the division’s Maternity and neonatal perinatal Culture leadership plan.

2. Quality and Safety

2.1 Clinical Outcomes/ Dashboard

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

Current areas of focus:

- **Intra-uterine deaths occurring prior to the onset of labour**. During Q2 2025/26, four intra-uterine deaths were reported that occurred before the onset of labour. This represents a slight increase compared with three cases in Q1, bringing the total for the year to date to seven cases. In comparison, there were ten cases reported in the full year 2024/25. Each case undergoes an immediate multidisciplinary team (MDT) review, and the national Perinatal Mortality Review Tool (PMRT) is completed, including input from an external reviewer. All four cases in Q2 have completed their MDT review; one case identified an issue that may have contributed to the outcome. Further details will be explored within the Perinatal Mortality section below.
- **Complaints.** During Q2 2025/26, the maternity service received thirteen complaints, representing an increase compared with the previous quarter. All complaints are investigated by the appropriate manager, and learning from each case is shared across the service to support quality improvement. The number of complaints and any emerging themes continue to be monitored and discussed through the Divisional Governance Meetings.

Previous areas of focus where improvement is being sustained:

- **Perineal Trauma**. There has been a reduction in the number of women experiencing severe perineal trauma during Q2 2025/26. The total number of cases for the year to date is 28, with a rate of 2.7% since April — a sustained improvement from 3.4% at the end of Q1. The work of the Pelvic Health Team continues to contribute to improved outcomes for this group of women and to promote proactive measures to support prevention and recovery.
- **Induction of Labour.** Rates remain elevated compared with previous periods; however, the overall rate at the end of Q2 2025/26 is 32.9%, which is in line with the national average of 33%. MWL participated in an Induction of Labour (IOL) survey in collaboration with the Cheshire and Mersey LMNS. The results were due to be published in September 2025 and are still awaited.

2.2 Perinatal Mortality

Perinatal mortality data forms part of MIS Safety Action 1.

Perinatal mortality includes any fetal loss from 22 weeks' gestation, stillbirths, and neonatal deaths occurring within the first 28 days of life. All eligible perinatal deaths are notified to MBRRACE-UK and reviewed using the national Perinatal Mortality Review Tool (PMRT).

Each perinatal mortality incident undergoes an initial multidisciplinary review to assess the degree of harm, identify any immediate learning, and determine whether the incident meets the criteria for STEIS reporting.

For the Q2 2025/26 reporting period, there were four reportable perinatal deaths.

Q2 2025/26	Total	
July	1	1 Stillbirth on Whiston site. - FDIU at 29 weeks gestation.

August	0	
September	3	3 Stillbirths on Whiston site. - FDIU at 38+3 weeks. Arrived via ambulance with a placental abruption. USS confirmed FDIU. - FDIU at 26 weeks. Attended triage with reduced fetal movements and FDIU diagnosed. - FDIU at 39 weeks. Attended triage after feeling no fetal movements for a number of hours. FDIU diagnosed.

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

July 2025: 1 Stillbirth

Case 1) Whiston site: A stillbirth occurred at 29+3 weeks' gestation following the woman's attendance at Maternity Triage at 29+1 weeks with a history of no fetal movements for over 24 hours, where an intra uterine death was confirmed. It was identified that 35 hours prior to this attendance, the woman had presented to the Emergency Department with non-obstetric symptoms and reported reduced fetal movements. A midwife attended ED and auscultated the fetal heartbeat but did not perform a CTG at that time in line with the reduced fetal movement guideline. Delivery occurred 49 hours post confirmation of the intrauterine death. Postmortem and placental histology findings indicated that the cause of death was fetal vascular malperfusion associated with an over-coiled umbilical cord. The findings suggest that the baby was likely to have died at least four days prior to delivery. The case underwent an initial clinical review prior to the receipt of postmortem results which highlighted the issue regarding not performing a CTG. The case is scheduled for review at a PMRT multidisciplinary panel in November, where the postmortem findings and the care provided during the woman's ED attendance will be considered before a final grading of care is determined.

September 2025: 3 Stillbirths

Case 1) Whiston site: A stillbirth occurred at 38+3 weeks' gestation following the woman's attendance at Maternity Triage via ambulance with symptoms suggestive of a concealed placental abruption and an intrauterine death was diagnosed on admission.
The case has undergone a multidisciplinary review, and no issues were identified that would have altered the outcome. The PMRT review is scheduled for Q3, once all relevant pathology results have been received.

Case 2) Whiston site: A stillbirth occurred at 26+2 weeks' gestation following the woman's attendance at Maternity Triage with a history of no fetal movements from the previous day and an intrauterine death was diagnosed. The parents in this case declined all clinical investigations to determine a cause of death. A clinical review was conducted using the available information and no issues were identified that would have affected the outcome for the baby.

Case 3) Whiston site: A stillbirth occurred at 39+1 weeks gestation following attendance at triage the previous day (39+0 weeks) with six hours of absent fetal movements. On arrival, an intrauterine death was diagnosed. The case underwent a clinical review, which identified issues that would not have affected the outcome in which shared learning is undertaken. A PMRT review will be scheduled in Q3 once all relevant pathology results have been received.

There were ongoing PMRT cases that were reviewed in Q2 and included three cases that occurred in Q1, as well as two cases previously reviewed by PMRT panels at Whiston.

Stillbirth – May 2025, 34+3 weeks gestation: A mother was booked for birth at Whiston but lived outside our geographical area. As she was assessed as low risk, the majority of her antenatal care was provided by community midwives from a neighbouring Trust. The cause of death was determined to be a placenta with high-grade fetal vascular malperfusion and mild maternal vascular malperfusion. At review, it was noted that the baby was small for gestational age at birth, although this had not been identified during antenatal ultrasounds. The scan images were subsequently reviewed by an external fetal medicine specialist, who concluded that both the images and measurements were acceptable and that the estimated fetal weights

were within the nationally accepted range when compared to the birthweight. The panel concluded that no issues were identified with the care provided in this case.

Stillbirth – May 2025, 32+6 weeks gestation: The woman, whose first language was not English, was initially booked for birth at Ormskirk however during her pregnancy, she developed gestational diabetes. Congenital abnormalities, along with placental circulation issues, were identified in the developing baby via USS and care was subsequently transferred to Whiston site. An intrauterine death was diagnosed during planned monitoring in the Fetal Medicine Assessment Unit (FMAU). An external opinion from a fetal medicine specialist at a regional centre was sought due to the complexity of the case. Issues identified included:

- Communication with the regional fetal medicine unit could have been initiated when abnormal dopplers were identified to support an antenatal management plan and determine the timing of delivery.
- Staff did not document reasons for deviating from the planned readmission at 32+1 weeks, instead arranging admission at 32+3 weeks.
- Staff did not adhere to Trust-wide policies regarding patient communication, including interpretation, translation, and the Accessible Information Standard. A relative was used as an interpreter without documenting prior discussions with the woman or obtaining consent to use family members for interpretation.

The panel agreed that the issues identified in this case may have influenced the outcome for the baby.

Stillbirth – June 2025, 39+1 weeks gestation: The woman received all antenatal care from a neighbouring Trust, where she had planned to give birth. At 39 weeks, she experienced reduced fetal movements. Due to high acuity at the neighbouring Trust, Whiston Hospital provided mutual aid to review. On admission, intrauterine death was diagnosed, and the woman chose to continue her care at MWL.
An issue identified care provided by the neighbouring Trust which related to:

- When concerns regarding the baby's growth were noted, counselling was provided by a midwife, however, an obstetric referral was not made after woman declined induction of labour.

The PMRT review concluded that this issue may have influenced the outcome for the baby. No issues were identified with the care provided by services at MWL.

The perinatal mortality findings have previously been summarised within the maternity and neonatal update reports. The full perinatal mortality report for Q1 2024/25 for both maternity sites have been completed and are attached as Appendix 3.

2.3 Serious Incidents

Never Events

No never events occurred in this reporting period.

Serious Reportable Incidents

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

During this reporting period there was 1 serious incident on the Ormskirk site in July. This relates to a baby who underwent active therapeutic cooling due to suspected hypoxic-ischaemic encephalopathy and the case was referred and accepted by MNSI.

2.4 Maternity and Neonatal Safety Investigations

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

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

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

- Concerns raised by the Trust regarding the care provided

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

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

Cases to Date April 2019 to September 2025	Ormskirk	Whiston	Total
Total Referrals	**18**	**55**	**71**
Referrals / Cases Returned to the Trust / Rejected	7	21	28
Total Investigations to Date	11	34	45
Total Investigations Accepted	11	34	45
Total HSIB Investigations Completed	10	31	43
Current Active Cases	1	1	2

MNSI Case Update

Ormskirk Site:

- Two new cases were referred to MNSI during Q2, one of which was accepted.

Case 1: A baby born at Ormskirk met criteria for active therapeutic cooling. Cooling was initiated, and the baby was subsequently transferred to a regional neonatal intensive care unit (NICU) for ongoing management. The infant completed 72 hours of active therapeutic cooling and was discharged home on day 7 postnatally under the care of the Community Midwives and GP.

An MRI scan was performed, with normal findings reported. The case was referred to MNSI and accepted for investigation following parental concerns. The MNSI investigation remains ongoing.

Initial findings have highlighted the following areas for review:

- Assessment and review of growth ultrasound (USS) images
- Management and role of the lead neonatologist during neonatal resuscitation, including a full review of neonatal records and the escalation process

Case 2: A mother presented in spontaneous labour at 40+3 weeks' gestation and progressed to a normal vaginal delivery, complicated by a shoulder dystocia.

The baby required resuscitation and was transferred to the neonatal unit. The infant met criteria for active therapeutic cooling and was transferred to the regional unit to complete 72 hours of therapy. An MRI of the brain performed at 7 days of age showed normal findings, and the baby was subsequently discharged home.

The case was referred to MNSI and subsequently declined as the criteria was not met due to the normal MRI results and the parents declined an MNSI investigation. A PSIR is currently in progress.

Whiston Site:

At the end of Q2, one case that occurred at the end of Q3 2024/25 had completed its investigation, and the report from MNSI is awaited. This case experienced significant delays as the postmortem for the neonatal death was pending release by the coroner, and MNSI was unable to release their report until this occurred. The report is now expected early in Q3.

During Q2, the services at Whiston received two reports: one relating to a case from the end of Q3 2024/25 and one from a case in Q4. Both cases highlighted several areas for learning, and actions are being implemented to improve care, including:

- Updating the CTG “Fresh Eyes” assessment sticker to ensure that contractions occurring at a rate of 5 in 10 minutes are clearly flagged as hyperstimulation for obstetric escalation.
- The requirement to remove Propess pessaries after 24 hours in the induction of labour guideline.
- Collaboration with the Neonatal Network to ensure that babies suspected of birth-related brain injury receive an MRI within 15 days of birth, with recognition of the challenges posed when babies transfer between different NICU and NNU settings.
- Aligning guidance on the management of women with low PAPP-A across the guidelines for fetal growth restriction, antenatal screening, and antenatal care, including the booking appointment.
- Reviewing current maternal observation charts and providing additional training and information to staff as an interim measure until the new maternity information system and electronic patient record are implemented.
- Expanding neonatal resuscitation skills drills to include ongoing care on the neonatal unit, covering areas such as admission assessment, care planning, and implementation of care in the first two hours of life.

2.5: Neonatal Medication Incidents

During the Q2 reporting period, there were 22 medication incidents reported within the Neonatal Units (NNU) of MWL. This represents an increase from 11 incidents in Q1. The rise is attributed to an improvement in reporting culture, following focused work with the teams to encourage openness and learning from incidents. Medication incidents during this quarter were categorised as either medication prescribing, administration or delivery errors. 17 incidents were categorised as no harm, four low harm and one moderate harm caused.

Three incidents which caused low harm involved delayed antibiotic administration at Whiston. Whiston are currently piloting the prescription booklets used at Ormskirk to improve prescribing and minimise administration errors and delays. Pharmacy have recommended that the prescription booklets remain on the NNU if the neonate is under transitional care and a collaborative working group between Maternity and Neonatal teams has been convened to operationalise this.

The other low harm incident involved an IV administration error of a morphine infusion at Ormskirk. Ormskirk are planning to roll out the drug library infusion pumps in January 2026 which should reduce administration errors of medicine and fluid infusions.

The incident which caused moderate harm was for a neonate at Whiston who had a 15-hour delay in receiving antibiotics for neonatal sepsis. There were prescribing issues with the prescription Kardex and the neonate also required re-cannulation.

Appropriate action was taken on all occasions as the incidents were escalated and rectified

Number of medication incidents				
Location	Q1	Q2	Q3	Q4
Ormskirk	3	7	-	-
Whiston	8	15	-	-
Total	**11**	**22**	**-**	**-**

Category	Q1	Q2	Q3	Q4
Medication - storing	0	0	-	-
Medication - prescribing	45.5%	31.8%	-	-
Medication - administration	54.5%	63.7%	-	-
Medication - delivery	0	4.5%	-	-
Medication - preparing	0	0	-	-

Key observations during this period:

- Unintentional omission or delay of medicines including critical medicines such as antibiotics. Not anticipated to have long term consequences.
- Misplaced neonatal prescription charts between the postnatal ward and the NNU
- Significant drug infusion administration error. Not anticipated to have long term consequences.

Recommendations:

Location	Action	Update	Due date
Ormskirk and Whiston	**Introduction a new prescription booklet for NNU** *specifically for only the Unit to use. This has had multi-disciplinary input from the clinical director, the ward manager, senior neonatal nurses, advanced neonatal nurse practitioners and pharmacy. This new chart will include a gentamicin prescription page within it, similar to the chart used at Whiston, to aid prescribing and drug monitoring*	03/02/2025 – administration chart goes live at Ormskirk 04/2025 – Whiston to move to same prescription booklet, undergoing their governance process 10/2025 – Whiston currently piloting the prescription booklet with consultant paediatrician and NNU ward manager leading the trial	Complete – Ormskirk October 2025 - Whiston
Ormskirk/Whiston	**Introduction BBraun drug library on NNU** *to aid administration of medication and reduce the number of incidents in relation to this*	30/06/2025 – response from Bbraun received, currently prioritising adult and obstetrics and gynaecology drug libraries 08/08/2025 – teams call arranged with BBraun to plan proof of concept day and subsequent roll out 09/2025- proof of concept day complete 10/2025 Bbraun meeting, roll out week commencing 12th Jan 2026 at Ormskirk	March 2026
Ormskirk/Whiston	**Introduction IV drug monographs** *and moving away from using Medusa as considered not fit for purpose on an NNU. These monographs have had multi-disciplinary input from pharmacy, advanced neonatal nurse practitioners, and senior neonatal nurses*	04/2025 – Whiston team wish to use the monographs and have agreed to support with ongoing project 07/2025 –confirm local neonatal monographs uploaded to Medusa and Eolas 10/2025 – 28 drug monographs ratified	Ongoing
Ormskirk/Whiston	**Introduction of Numeta G13% and G16% PN guideline** *to help reduce the risk of compounding errors, infection and medication errors associated with TPN. It will replace ITH ordering of TPN for Ormskirk making it more cost effective and will allow babies to receive lipid soon after birth and improve long term growth outcomes.*	07/2025 – ratified at Ormskirk Paediatric Departmental Meeting, MWL Drugs and Therapeutic Group and Clinical Effectiveness Committee 08/2025 – prescription booklets ordered, and training arranged 09/2025 – implementation of Numeta at Ormskirk	Complete – Ormskirk December 2025 - Whiston
Ormskirk/Whiston	**MWL Women's and Children's working group** *to bring together the pharmacist service and collaborate decision-making and clinical practice.*	06/2025 – monthly women's and children's pharmacist meetings between Whiston and Ormskirk arranged	Complete

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

2.6 Saving Babies Lives (SBL) Care Bundle

Compliance with all elements of the Saving Babies' Lives Care Bundle Version 3 remains a requirement for Safety Action 6 for MIS Year 7.

The Q2 LMNS quarterly improvement discussion meeting, was the first meeting where merged data from both sites was considered. The service was asked to provide merged data for the first time, which revealed a reduction in overall compliance to 88% across both sites, compared with the previous compliance of 99% at Ormskirk and 99% at Whiston. As a result, it is no longer possible to directly compare progress data. Furthermore, the NHS England toolkit has been updated, introducing new stretch compliance requirements that differ from those used in Q1 2025/26 which require a higher compliance rate.

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

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

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

Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction
Compliance has decreased. Services are transitioning from GROW 1.5 (paper-based) to GROW 2.0 (electronic) for monitoring fetal growth. An action plan is in place for full implementation.

The service is also reviewing capacity to introduce a reduced scan interval (from 3–4 weeks to 3 weeks) for at-risk women of a small for gestational age or growth restricted baby, in line with the Regional Guideline. If the current 3–4-week interval is retained, a Trust-specific guideline will need to be drafted and receive LMNS approval.

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

Element 4: Effective Fetal Monitoring in Labour
Sustained 100% compliance.

Element 5: Reducing Preterm Birth

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

No evidence was uploaded from the Ormskirk site relating to the rates of intraventricular haemorrhage in neonates from the NNU's NNAP data, this should be available for the next evidence submission, and this therefore affected the overall compliance rates.

For the Whiston site, the issue related to documentation and confirming to the LMNS that there were no cases that occurred in Q4 and therefore no audit was required.

Element 6: Management of Pre-existing Diabetes
Five of six recommendations are fully compliant.

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

The LMNS remain satisfied with the ongoing progress of MWL in implementing the Saving Babies' Lives Care Bundle, with monitored action plans focused predominantly on audits and documentation and noting the changes introduced increasing the compliance target.

2.7 Care Quality Commission CQC Review

The maternity service CQC inspection on 7th and 8th December 2023 rated the services as:
- Whiston: Good overall and good for being safe and well-led
- Ormskirk: Good overall and for being well-led. It was rated requires improvement for being safe.

Ormskirk areas for improvement

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

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

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

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

Whiston areas for improvement

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

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

Progress in delivering the Maternity Action plan

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

In relation to ensuring enough staff are available, a robust rolling recruitment programme is in place to ensure timely recruitment into vacancies which may arise during the year, and an open evening was undertaken in May 2025 to showcase opportunities for new registrants at MWL in Maternity and Neonatal Services.

Following interviews posts were offered to newly qualified registrants due to commence in role in October on receipt of their NMC PIN

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

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

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

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

2.8 Antenatal and Newborn Screening Quality Assurance

Work continues on implementing the recommendations from the successful Screening Quality Assurance visit in early 2025. The first feedback meeting was held on 22 August, during which:

- 7 of the 39 actions were closed
- A further 6 actions were agreed for closure pending submission of additional evidence, which has now been provided.

All remaining actions are progressing on schedule, except for one item, which has been escalated to the Sonography departments for urgent completion by 31 October.

While the February visit identified no immediate or urgent concerns and only recommended non-urgent service improvements, completion of all actions is expected to enhance the safety and quality of the Antenatal and Newborn Screening service.

Key areas of focus include:

- Harmonising guidelines while updating them to align with national policy
- Increasing service resilience through cross-site working within the team
- Collaborating with paediatrics to implement a NIPE competency framework

The updated action plan is presented to the committee as Appendix 4.

2.9 Safety Champions

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

Safety Champion Walkarounds for both sites are scheduled throughout 2025, providing opportunities for frontline clinical and non-clinical staff, as well as women and their families, to raise any safety concerns. Feedback from these walkarounds is discussed at the Maternity Safety Champion meetings. The feedback proforma has been updated to record whether safety actions have been identified and where these have been escalated for action or oversight.

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

The Maternity Safety Champions review the Perinatal Quality Surveillance Model (PQSM) tool on a monthly basis, with findings reported to the Board. The PQSM tool is also presented to the Committee and included as Appendix 5.

2.10 Complaints and Claims.

Maternity:

There were 13 formal complaints received in Q2 for Maternity. Analysis of the complaints received during the reporting period has highlighted recurring themes relating to both communication and the care and treatment provided. Patients and their families have expressed concerns about the clarity and sensitivity of information shared, as well as aspects of the clinical care experience during their pregnancy and postnatal journey. These themes suggest opportunities to strengthen how we engage with patients, ensure consistent communication across care pathways, and continue to promote a compassionate and responsive approach to treatment.

Maternity	July 2025		August 2025		September 2025		Total	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston
Number of Complaints	3	3	2	2	0	3	5	8

Learning and Actions from Closed Complaints

The remaining open complaints from Q1, relating to the Whiston site (received in May) and the Ormskirk site (received in June) were investigated, and responses were provided to the respective complainants. Two further responses for the Whiston site, received in July, were closed within the 60-day timeframe. All other complaints remained under investigation and are on track to be responded to within the required timescales.

- Ensure ongoing and compassionate communication with families during periods of care, including when awaiting the ARM for the continuation of an IOL procedure.
- Verify patient contact details via the PAS system to prevent transcription errors, particularly when verbal information has been received from a neighbouring Trus

Neonatal:

Neonatal	July 2025		August 2025		September 2025		Total	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston
Number of Complaints	0	0	0	0	0	0	0	0

Neonatal Services had no outstanding complaints from Q1, and no formal complaints were received during Q2.

Claims

In Q2 2025/26, there was one new claim for the Maternity Service and no claims for Neonatal Services.

The claim received in July related to concerns of antenatal care at the Ormskirk site and alleges a failure to identify congenital cardiac abnormalities during a fetal anomaly scan in 2021 thereby not meeting national standards. After a term birth, the baby was found to have a heart murmur during the newborn examination. Following transfer to Alder Hey Children's Hospital, an echocardiogram confirmed a diagnosis of several congenital abnormalities. The child has since undergone multiple operations and may ultimately require a heart transplant. The claim asserts that, had the fetal anomaly scan been conducted correctly and the diagnosis made antenatally, the parents would have chosen to terminate the pregnancy.

Upon birth, the baby's unexpected transfer to the neonatal unit was reported as an incident, and a review of the original scan images was undertaken. At the time, no issues were identified that would have influenced the outcome, noting that fewer than 50% of congenital cardiac abnormalities are detected during the Fetal Anomaly Scan. A further review of the case is currently underway following receipt of the claim.

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

The details for the new combined scorecard are:

The Top 5 injuries by volume for obstetrics:

1 Psychiatric/psychological damage
2 Stillborn
3 Fatality
4 Unnecessary Pain
5 Brain Damage

The Top 5 Causes by volume within the scorecard were:

1 Failure or delay in treatment
2 Failure/delay diagnosis
3 Fail to monitor first stage of labour.
4 Fail to monitor second stage of labour.
5 Failure to make a response to abnormal fetal heart rate.

The claim received in Q2 relates to a failure or delay in diagnosis. A review of the Claims Scorecard indicates that, since 2015, there have been no claims associated with a failure or delay in diagnosis specifically concerning failure to identify a congenital abnormality.

2.11 Maternity Red Flags

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

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

The following red flags should be documented using the Incident Reporting System:

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

Theme	Total for Q2 2025/26							
	July 2025		August 2025		September 2025		Total	
	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk
Delayed or cancelled time critical activity	0	0	0	0	0	0	**0**	**0**
Missed or delayed care	0	0	0	0	0	0	**0**	**0**
Missed medication	0	0	0	0	0	0	**0**	**0**
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	**0**	**0**
Delay of 15 minutes or more between presentation and triage	2	0	3	1	5	0	**10**	**1**
Delay of 30 minutes or more between presentation and triage	0	0	0	0	0	0	**0**	**0**
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	**0**	**0**
Delay of 2 hours or more between admission for induction	0	2	0	0	1	0	**1**	**2**
Delay in transfer to delivery suite for ARM	0	1	0	0	0	0	**0**	**1**
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**	**0**
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	0	0	0	**0**	**0**
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0	**0**	**0**
TOTAL	**2**	**3**	**3**	**1**	**6**	**0**	**11**	**4**

Four Midwifery Red Flags were reported on the Ormskirk site during Q2. In July there were 2 delays in commencing the induction process and 1 delay in transfer to Delivery suite for ARM which were all attributed to acuity on the unit at that time. There was one occasion in August where a patient was not seen in maternity triage within 15 minutes of arrival. This was due to the midwife's oversight, and the patient was seen within 25 minutes.

During this reporting quarter, there were 11 Midwifery Red Flags recorded on the Whiston site. Of these, 10 were related to delays between presentation and triage, reflecting an increase from the previous quarter; however, it is important to note that none of the delays exceeded 30 minutes. This demonstrates an improvement in timely triage and effective management of workload pressures, even with the slight increase in reported MRFs. Staff continue to be proactive in escalating concerns to the Maternity Bleep Holder, who provides timely support and coordinates redeployment of staff to mitigate risk. This proactive approach has contributed to maintaining delays within safe parameters.

Ongoing monitoring and review of all incidents are undertaken by the Matron and Clinical Lead for triage to identify any recurring themes or learning opportunities and support continuous improvement by conducting a full breach analysis on every incident. Findings indicate that when delays occurred, they were associated with periods of high call volumes or multiple simultaneous attendances. There were no adverse outcomes related to these delays, and all women were triaged as soon as possible.

The Whiston Triage telephone system continues to provide a robust failsafe mechanism during periods of high acuity. In Quarter 2, the department answered 5103 calls and recorded 1771 attendances, achieving a 99.43% compliance rate for triage within 15 minutes of arrival.

The remaining one MRF related to an induction of labour delay, which was reviewed and confirmed as appropriate given the clinical context.

The role of the Delivery Suite Shift Coordinator remains a key component of safe intrapartum care and continues to meet full compliance with national recommendations, including those outlined in the Ockenden Report. The coordinator remains supernumerary 24/7, ensuring effective leadership, oversight, and communication across the unit. Monthly audits presented at the Maternity Governance Meeting continue to show 100% compliance with this requirement. Documentation completed by the Maternity Bleep Holder confirms at least every four hours that the Shift Leader remains supernumerary, with any exceptions fully recorded and justified.

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

3. Workforce

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

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

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

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

The Maternity Service has commenced discussions regarding the next required Birthrate+ (BR+) workforce review for 2025/26, meeting the expectation that a systematic, evidence-based process to calculate the midwifery staffing establishment will be undertaken within a three-year cycle, as set out in MIS Year 7. A meeting with the Birthrate+ team took place in September 2025 to agree the requirements for MWL and work will be ongoing during Q3 and Q4 to collate the required data from within the service with a report anticipated by the end of the financial year. This will be the first workforce review undertaken collaboratively as MWL.

The Maternity Bi-annual staffing reports were presented to the Committee in September within the Q1 report. For completeness they are included as Appendix 6 for inclusion at Trust board in November as a requirement of MIS.

Ormskirk Maternity Service:

The number of births recorded at MWL (Ormskirk site) between July to September 2025 was 503, which is a decrease of 53 births (9.53%) on the same quarter in 2024/2025. In comparison to Q1, births decreased by 44 (8.05%)

There were 619 bookings in Q2 which is 1 booking less than Q1 2024/25. However, comparing the Q2 bookings Q2 in 2024/25 there has been an increase of 29 bookings (5%)

The January 2022 BR+ report identified that the Delivery Suite case mix for 2021 indicated that 58.2% of women were in the 2 higher categories IV and V which was in keeping with the average for England of 58%. This was an increase of 7% compared with the 2018 report of 51%, which reflected the increase of induction rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The overall funded Midwifery establishment is 131.21wte inclusive of 5.28wte Band 3 MSWs who are based on the maternity ward and providing clinical care in line with the recommendations of the Birthrate plus report. The midwifery establishment is divided into direct clinical care and non-direct clinical care.

The recommendation for the funded establishment for the provision of direct midwifery care from BR+ was 107.89WTE which included a 25% uplift for annual leave, sickness, and study leave based on the births which was 2387 and forward bookings for 2020/2021.

The reporting timeframe of July to September 2025 identified the funded establishment as being above this recommended figure at 115.39WTE which includes 5.28WTE maternity support workers. This includes a funded establishment for direct clinical care reflective of a 30% uplift that was approved following the Birthrate+ assessment to enable designated staff for elective caesarean lists and externally funded posts.

The BR+ report identified that 9.51WTE was recommended as the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical whole time equivalent. The current funded non-direct care equates to 15.82WTE. It is noted a slight decrease from the previous biannual staffing paper, due to a review of the direct and non-direct hours component of specialist midwives' roles and therefore a redistribution of non-clinical hours to clinical hours was adjusted. The contracted establishment is currently 15WTE and below the funded establishment due to vacancies for 0.1WTE Matron, (temporary reduction of hours and returning to full time hours on 1st November to support pension draw down) and vacancies for 0.12WTE infant feeding midwife and a 0.6WTE Band 6 MSW retention midwife. The current funded establishment relates to 12% of the total clinical establishment which is above the BR+ recommendations of 9% and is due to additional funding from Ockenden and externally funded posts.

The additional staff include the provision of cover for elective caesarean section lists, increased training due to Ockenden recommendations alongside 3.6WTE band 7 externally funded posts which include 1WTE smoking cessation midwife, 0.4WTE bereavement midwife, 1WTE preceptorship/ workforce midwife, 0.2WTE pre-term birth/ multiple pregnancy midwife and 1WTE band 7 digital midwife secondment in place to support the implementation of the new electronic maternity system funded via the digital transformation monies. There is also a 0.6WTE Band 6 midwife for MSW retention vacancy.

The staffing position at the end of September 2025 identified that the unit was not in deficit to the BR+ funded establishment recommendations for direct or non-direct maternity care.

The current vacancy was 7.21wte across all clinical midwifery posts, with 3.9WTE newly qualified midwives due to commence in post on 6th October following completion of their course and receipt of their NMC Pin.

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

Month	Midwife to Birth ratio
April 25	1:21
May 25	1:21
June 25	1:21

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

Whiston Maternity Service:

The number of births at MWL (Whiston site) between July and end of September was which was an increase of 71 (8.1%) compared to the previous quarter, and a 2.8% increase compared to the same reporting period in 2024.

Bookings increased to 1009 in Q2, which is a 1.3% increase from same period in 2024.

The last BR+ report which was received by the Trust in October 2022 identified that the generic case mix, 55.6% of women were in the 2 highest categories of care required which is slightly below the average for England of 58% with the DS case mix indicating that 60.9% of women are in the highest 2 categories for care within the DS environment which is an increase of 9% from the previous BR+ assessment in 2016. This

reflects the increase in induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions up to 2022.

The induction and of labour and caesarean section rates have continued to rise into 2025, supporting that although overall the national trend is a declining birth rate, there has been an increase in complexities of care for women during pregnancy, birth and the postnatal period

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and identified that 14.49 WTE is the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment is 14.39 WTE and aligns to the recommendations and therefore no variance is noted. In addition, the non-direct care band 7 posts include three fixed term externally funded posts (2.2WTE) which are included in the contracted figures but not in the funded establishment. If external funding ceases, there will be a requirement to complete a business case for these roles as they are required within the service as they are fundamental in supporting improving outcomes for vulnerable women and babies, and providing retention support to the workforce

The BR+ report identified that the required WTE for the provision of direct maternity care was 160.98 WTE and the current funded establishment is 167.22 WTE. Agreement to substantively over establish to cover maternity leave is maintained and the service is therefore in line with the recommendations of the BR+.

A recruitment open evening and interviews were undertaken in June 25 to recruit to MWL midwifery vacancies and ensure a reserve list should any vacancy gaps arise due to recruits withdrawing, promotion, reduction in hours, retirements, and leavers currently working notice period.

As of end of end of Q2, the actual midwifery vacancy was 2.16 WTE. A proportion of this, 0.12 WTE, has allocated to a Band 6 midwife to increase their contracted hours, and the remaining 2.04 WTE offered to newly qualified midwives commencing in post during the first week of October, on receipt of their NMC PIN. MSW actual vacancy was 2.64 WTE with all posts offered and successful candidates undergoing recruitment checks with an anticipated start date by Month 9. Our ongoing rolling recruitment programme continues to ensure any deficits are advertised as early as possible and that a proactive approach is adopted to fulfil vacancies that arise to maintain safe staffing levels across the service.

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

Month	Midwife to Birth ratio
July 25	1:24
May 25	1:25
June 25	1:25

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

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

Obstetric Workforce.

Obstetric Staffing relates to Safety Action 4 of MIS

The Whiston and Ormskirk sites are fully recruited to the funded Consultant establishment. However, one Consultant based at the Ormskirk site is currently on secondment to Manchester Foundation Trust in Urogynaecology, creating a temporary vacancy. Recruitment to this post is ongoing, as the locum who had initially agreed to cover has since withdrawn their offer.

One Consultant vacancy is currently being covered by a fixed-term appointment.

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

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

The Royal College of Obstetricians and Gynaecologists (RCOG) has issued guidance to ensure the safe engagement of locum doctors. The guidance distinguishes between short-term locums (placements of two weeks or less) and long-term locums (over two weeks). It emphasises that healthcare providers must carry out robust recruitment checks, provide comprehensive local induction and supervision, and ensure locums are assessed for competence before undertaking independent or out-of-hours duties. From February 2023, doctors undertaking short-term tier 2/3 on-call locum roles must hold a Certificate of Eligibility (CEL) to evidence their competencies. The overarching aim of the guidance is to maintain safe staffing, mitigate risks associated with unfamiliarity, and ensure locums are effectively supported within maternity units.

Although MWL has not engaged long term locums, 100% of those undertaking short-term locums hold the certificate of eligibility. The audit report is attached as Appendix 7.

Neonatal service

A transformation programme is currently underway across Cheshire & Merseyside, with a renewed focus on implementing changes to the existing commissioned capacity. However, timescales from the Neonatal Operational Delivery Network (ODN) remain unclear.

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

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

Neonatal medical workforce

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

Neonatal staffing relates to Safety Action 4 of MIS and requires the neonatal unit to meet the BAPM national standards of medical staffing with compliance required to be recorded in the Trust Board minutes. This report will be presented to Trust Board in November 2025 detailing compliance.

Neonatal nursing:

Safety Action 4 requires the neonatal unit to meet the BAPM neonatal nursing standards or if the standards are not met, there is an action plan with progress against any previously developed action plans and monitored via the risk register. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

Ormskirk neonatal nursing service:

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

There is currently a 1.2 WTE vacancy within the team. This is being managed through existing resources and support from NHSP as required. Recruitment approval has been received, and interviews have been arranged.

Whiston Neonatal nursing service:

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

- 0.92 WTE Band 6 (Fixed-Term Contract) – awaiting approval (a Band 5 currently on hold following recent Band 6 interviews will be placed into this post)
- 0.92 WTE Band 5 (FTC) – vacancy from Band 5 stepping into Band 6 FTC
- 2.72 WTE Band 5 (Permanent) – recruited on 2 October 2025, not yet started
- 1.84 WTE Band 4 – vacancy
- 0.56 WTE Band 2 – vacancy

The Neonatal Unit continues to face significant pressures in Q2 due to high levels of Band 6 nurse unavailability:

- 2.47 WTE Band 6 nurses are off Long-Term Sick (LTS)
- An additional 0.6 WTE Band 6 nurse is due to commence a period of absence for surgery imminently
- 1.84 WTE Band 6 nurses are off LTS due to an ongoing HR investigation, which is expected to conclude in the coming weeks

All absent staff are being managed in line with Trust HR policies.

Additional pressures exist due to:

- 1.84 WTE Band 4 vacancies
- 0.92 WTE Band 4 Nurse Associate on a career break following LTS

The neonatal unit on the Whiston site completed the Q2 workforce calculator tool which was submitted to the ODN in October 2025. The tool identified that there is now a deficit of 3.45WTE registered nurses based on activity levels. The tool includes a separate tab for transitional care staffing although transitional care on the ward to full BAPM standards has not been commenced as detailed in SA3. An action plan has been developed which includes the requirement to review the nursing establishment, undertake a business case and review the neonatal cot configuration. The action plan will be presented to Trust Board, ODN and LMNS in November 2025 and will be monitored via the risk register and included in the quarterly maternity and neonatal update papers to Quality committee.

The Neonatal Nursing Workforce Summaries are included in Appendix 8 and the Whiston site action plan is presented as Appendix 1 as detailed in the MIS section earlier in the report.

Qualified in Speciality (QIS) trained staff across MWL.

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

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

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

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

Ormskirk Site:
The current QIS compliance on the Ormskirk site is 68.9%, with an ongoing plan in place to ensure all staff complete training. An additional 1.92 WTE staff are scheduled to complete QIS in November 2025, 0.96 WTE in December 2025, and 0.96 WTE in January 2026. A further 0.96 WTE will commence QIS training in

January 2026. Ongoing monitoring and support will ensure that compliance continues to improve and is sustained.

Whiston Site:
Current QIS compliance stands at 69%, reflecting a significant improvement following the successful completion of QIS training by 2.83 WTE (Four Nurses). One nurse commenced QIS training in September 2025, and one nurse with existing QIS qualifications has been recruited and commenced in role in October 2025. These actions support a projected compliance rate of 75% by March 2026.

QIS compliance fluctuates each quarter due to staff turnover, but current plans and training trajectories support the aim of maintaining and exceeding the 70% requirement.

FiCare Accreditation:

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

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

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

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

Neonatal UNICEF Baby Friendly Initiative (BFI) Accreditation:

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

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

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

Ormskirk: Achieved Stage 2 BFI accreditation in February 2025.
Whiston: Currently working towards BFI accreditation, with a date yet to be confirmed. A plan is in place for all staff to complete BFI training, and a nurse is being supported to undertake the BFI Train the Trainer course to enable future internal delivery and sustainability of training

Neonatal Transitional Care (NTC):

The Ormskirk site has a NTC service in place with NTC pathways in place. The Whiston site currently provides elements of the BAPM NTC framework with associated pathways in place. An action plan was developed and signed off by the Trust with clear timescales and evidence of progress towards full implementation being monitored following approved funding to staff a TC service compliant with BAPM.

The additional funding included additional nurse and maternity support worker staffing. Recruitment has proved challenging and has undergone numerous recruitment drives with several staff declining posts immediately prior to commencement and staff leaving after starting requiring further advertisement. Employed staff are in various stages of recruitment, orientation and training and alongside current vacancies, sickness and absence has resulted in deferments of implementation dates. A revised September implementation date was scheduled however continued vacancies, increased sickness and unavailability of neonatal nursing staff has deferred this date further with a revised commencement date of end March 2026. The Transional care action plan has been updated with revised timescales and is presented to the Committee in Appendix 1 as detailed in section 1 earlier in the report.

3.1 Sickness Including COVID

Sickness	July 25	August 25	September 25
Ormskirk Maternity	5.65%	6.71%	8.58%
Whiston Maternity	10.84%	11.31%	8.89%
Ormskirk Neonatal	8.67%	1.41%	8.55%
Whiston Neonatal	18.52%	8.88%	6.29%

Sickness is being managed according to the MWL policy, with monthly oversight and support from Human Resources.

3.2 Maternity Continuity of Carer

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

The Northwest Regional Maternity Team has provided interim direction, advising that the focus should be on delivering antenatal and postnatal continuity for these priority groups.

A further review of this model will be required alongside a review of the staffing necessary to support its delivery once the current funded establishment is achieved. The review will consider appropriate skill mix to ensure the model can be implemented if updated national guidance remains unchanged.

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

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

The MCoC Action Plan has been revised and refreshed following the alignment of the MWL Community Midwifery Service and is presented to the committee as Appendix 9.

3.3 Maternity Suspension of Services.

During the reporting period from July to September 2025, there were no suspensions of maternity services at either the Whiston or Ormskirk sites.

3.4 Neonatal Suspension of external services

Ormskirk site			Whiston site	
Q2 25/26	No of closures		Q2 25/26	No of closures
July 25	7		July 25	7
August 25	0		August 25	4
September 25	0		September 25	7
Total closures	**7**		**Total closures**	**18**

There were 25 neonatal suspensions of services in Q2 across MWL. Throughout these periods of closures which were to external admissions/ repatriation of babies from the tertiary referral unit. Both units remained open to emergency admissions with plans to stabilise and transfer any babies that required admission.

During the reporting period, Ormskirk NNU experienced closures on seven occasions. Closures occurred twice due to high acuity levels, where patient needs exceeded safe staffing capacity, and on five occasions due to staffing challenges. No women were required to be transferred to alternative providers due to these closures.

One woman booked to birth at Whiston in July required intra uterine transfer (IUT) >27 weeks pregnant due to the neonatal suspension of service who was counselled regarding the need for transfer by both the Neonatal and Obstetric Teams. The Cot Bureau identified availability at an alternative provider within the Cheshire and Merseyside area, and transfer was undertaken. The mother presented to Maternity Triage with suspected preterm labour at 27weeks +4 days. As no HDU cots were available, she was transferred to the tertiary centre and delivered her baby the following day. In September a woman who was an antenatal inpatient on the Maternity Ward for observation at 35+1 weeks gestation was transferred to the tertiary centre due to the neonatal closure, however she did not require delivery at this gestation and was discharged back to Whiston to continue receiving antenatal care.

3.5 One to One Care in Labour

Maternity Services aim to achieve 100% one-to-one care for women in established labour. Compliance with this standard is monitored and reported through the Safe Staffing Report and the monthly dashboard.
For Q2, there were no occasions in which one-to-one care in labour was not provided.

3.6 Maternity and Neonatal Safety Training

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

Key Areas of Training:

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

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

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

Ormskirk Site:

Rolling Annual Compliance at MWL as of 30th September 2025		
Fetal Surveillance	Consultant Obstetrician	100.0%
	Other Obstetric Doctors	69.2%
	Midwives	99.2%
PROMPT	Consultant Obstetrician	100.0%
	Other Obstetric Doctors	89.5%
	Midwives	96.1%
	MSW	92.6%
	Consultant Anaesthetist	100.0%
	Other Anaesthetic Doctors	68.8%
NLS	Midwives	93.0%
	Neonatal Consultants	99.0%
	Other Neonatal Doctors	100.0%
	Neonatal Nurses	80.0%
	ANNP	100.0%

Whiston Site:

Rolling Annual Compliance at MWL as of 30th September 2025		
Fetal Surveillance	Consultant Obstetrician	95.0%
	Other Obstetric Doctors	95.0%
	Midwives	100.0%
PROMPT	Consultant Obstetrician	90.0%
	Other Obstetric Doctors	53.7%
	Midwives	96.2%
	MSW	95.2%
	Consultant Anaesthetist	80.0%
	Other Anaesthetic Doctors	60.0%
NLS	Midwives	96.2%
	Neonatal Consultants	100.0%
	Other Neonatal Doctors	92.9%
	Neonatal Nurses	86.5%
	ANNP	100.0%

4. Patient Experience

The National 2024 NHS Maternity Survey was conducted, featuring 57 questions. MWL scored about the same as other Trusts on 48 questions, somewhat worse on 5 questions, and worse than expected on 4 questions.

These results were triangulated with other sources of patient feedback, including input from MNVP and Trust Safety Champions' walkarounds, where feedback was generally positive and did not reflect the themes from the national survey.

Additionally, feedback from PALS, Complaints, and FFT contribute to the triangulation, with key themes identified around antenatal waiting times, communication (ensuring women and families understand information at various points), and increasing opportunities for partners to stay overnight to offer support following birth following the purchase of some recliners.

A robust action plan was developed to address the findings from the national survey and has been shared with Maternity Staff. This plan is formally monitored at the Women and Children's Divisional Meeting and Patient Experience Committee to ensure oversight and drive continuous improvement.

Out of the 35 actions, 14 have been completed, 17 are on track, and 4 are currently rated amber—3 of these directly relate to the implementation of a new Maternity Electronic Patient Record (EPR) system, BadgerNet implementation in Maternity services commenced May 2025. A further amber action relates to funding required to purchase recliner chairs to fully implement partner overnight stays on the postnatal ward.

In Q3 the action plan will be reviewed, with any outstanding or ongoing actions carried forward into a newly developed action plan. This will be informed by the findings of the NHS National Maternity Survey 2025,

which was undertaken during the summer, with results scheduled for publication by the CQC in November 2025.

Maternity matrons, supported by the patient experience team, have created local surveys using the Tendable platform focusing on identified areas of concern. These surveys help assess the impact of completed changes and highlight additional areas for attention ahead of the next national Maternity Survey publication. This initiative also provides an opportunity to strengthen the promotion and uptake of the Friends and Family Test (FFT) among patients, supporting continuous improvement in patient experience feedback.

Managers and Clinical leads continue to share patient feedback during team meetings and safety huddles to ensure timely review and action. Daily walkabouts are incorporated within the Maternity Manager role to enable direct engagement with service users and their partners, allowing for real-time discussion and resolution of any concerns. Friends and Family Test (FFT) scores, comments, and emerging themes are reviewed monthly at the Local Maternity Governance meeting to inform service improvement. Inpatient Matrons also undertake walkabouts within the maternity departments to obtain direct patient feedback and implement actions where necessary.

Q2 results of Tenable survey for Antenatal Care in the Outpatient Clinics at both Ormskirk and Whiston completed face to face with service users by the Patient Experience team, provided positive feedback directly to the service.

	2025/2026 - Q2		
WARD	Jul-2025	Aug-2025	Sep-2025
Women's Maternity Outpatients Whiston	97.5%	95.33%	100%

Q2 Friends and Family Feedback (Positive %, Very Good/Good Response)

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

To increase response rates the 4 different QR codes have been re-shared to all staff, the maternity ward QR code has been added to the bedside information leaflet and stickers for antenatal and postnatal community with the QR codes on have been placed on the handheld Maternity notes (Antenatal) and the Child Health Red Book (Postnatal Community). Staff are encouraged to promote the option to provide feedback via these QR codes to the women and families they are caring for.

Qualitative feedback from various sources, including FFT, compliments and concerns was reviewed across all areas.

Ormskirk:

Area	July 25	Aug25	Sept 25	Trust Target
Antenatal	100%	100%	100%	95%
Birth/Delivery	90%	96%	93%	93%
Maternity Ward	94%	100%	100%	92%
Postnatal Community	No responses	No responses	No responses	91%

During Quarter 2, FFT feedback for the Ormskirk site highlighted recurring themes related to the quality of care overnight and care following caesarean section, including concerns from some women about being discharged home too early.

To address these concerns, daily walkabouts are now embedded within the roles and responsibilities of maternity managers, providing an opportunity to engage directly with women and their partners, listen to feedback, and respond to any issues regarding the care they are receiving.

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

Whiston:

Area	July 25	Aug 25	Sept 25	Trust Target
Antenatal	100%	100%	No responses	95%
Birth/Delivery	89.9%	100%	95.2%	93%
Maternity Ward	79.1%	93.3%	82.6%	92%
Postnatal Community	100%	100%	100%	91%

Antenatal Friends and Family Test (FFT) scores showed improvement across Quarter 2, achieving 100% positive feedback; however, no responses were received during September. Area Managers will continue to promote FFT completion across Women's Outpatients, Maternity Wards, and Community settings to ensure representative feedback is obtained.

A key theme identified previously with regard to antenatal care related to extended waiting times for appointments in Consultant Outpatient clinics at the Whiston site. Analysis of patient feedback indicated that delays were primarily associated with appointment scheduling capacity and clinic flow. Targeted improvement actions were implemented. Subsequent patient feedback has demonstrated a positive impact, with no recurring themes regarding waiting times identified in Quarter 2. This finding is, however, caveated by the absence of feedback in September. Ongoing monitoring and audit processes will continue to provide assurance that improvements are sustained and that patient experience remains positive, particularly as the service continues to navigate the impact of clinical pathway changes for the high-risk cohort and increased attendance on the Whiston site.

Comments received through the postnatal touchpoint highlighted several areas for review and improvement. Some feedback related directly to care provided on the Delivery Suite and were shared with the team and discussed at staff meetings to support reflection and improvement. Concerns raised regarding staff attitude and self-awareness have been addressed through a Quality Bus activity on the Postnatal Ward, completed to promote professional behaviour, empathy, and awareness in all interactions with women and families. The cleaning services supervisor has been contacted, and all cleaning staff have been reminded of the need to respect patient privacy and to be considerate when opening patient curtains during cleaning.

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

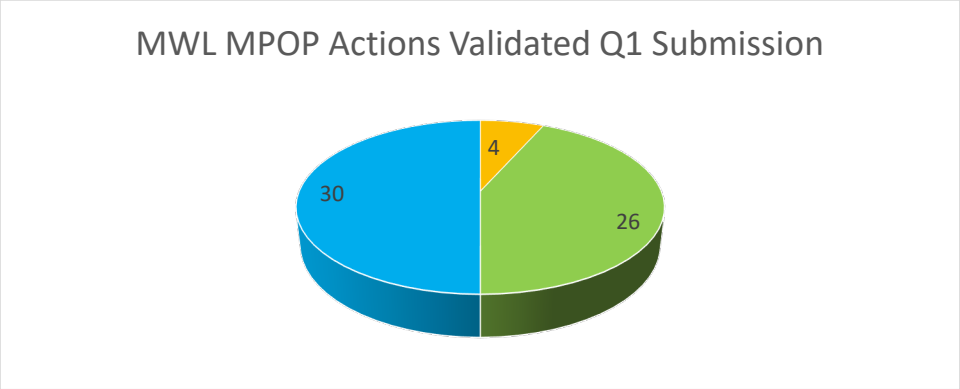
While most women report positive experiences with NHS maternity and neonatal services in England, independent reviews have highlighted cases where families have experienced unacceptable care, trauma, and loss. The publication of NHSE's Three-Year Delivery Plan for Maternity and Neonatal Services in March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

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

We are currently in Year 3 of the Three-Year Delivery Plan. The LMNS validated evidence for the Q1 submission, which was shared with the Trust during this reporting period, highlighting ongoing progress against MWL actions. Four actions are currently rated amber, relating to the Continuity of Carer (MCoC) implementation and rollout. Following discussions with LMNS, funding has been secured to strengthen MCoC teams, enabling the delivery of targeted support for the most vulnerable women and reducing health inequalities through the Amethyst team. Recruitment for Maternity Support Worker roles is underway. The

LMNS have also been updated on the current and ongoing alignment of the MWL Community Midwifery service.

The current BRAG status of all actions, following LMNS validation of the Q1 submission received by the Trust in August 2025, is presented in the chart below.



Q2 MPOP submission as provided to the LMNS in October 2025. The MPOP tool is presented to the Quality Committee in Appendix 10

6. Temporary maternity pathway changes

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

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

The pathway changes additionally extend to women who have emerging risks in pregnancy.

The pathway changes came into effect on 4th September 2025 and involved contact with 94 women who were identified as being in the defined high-risk categories and currently booked at our Ormskirk site alongside women who were registering a new pregnancy with the maternity service.

Following the recommendations by the LMNS and introduction of the temporary pathways, a review by the National maternity team was commissioned and scheduled for 6th to 9th October 2025. The review will cover both the Whiston and Ormskirk sites and include 1-1 reviews and focus groups during this assessment period.

Clinical workstreams have been set up alongside a clinical pathways project board to review, monitor and escalate any emerging concerns or risks.

The National maternity teams report is anticipated to be received approx. 4 weeks following the assessment and until the report is received the pathway changes remain will in place.

7. Recommendations

The Board is asked to note the report.

8. Summary of Appendices

- Appendix 1: Neonatal Transitional care action plan
- Appendix 2: Neonatal nursing staffing action plan
- Appendices 3a and 3b: Perinatal Mortality Reports Q1 2025/6
- Appendix 4: Screening QA Action Plan
- Appendix 5: PQSM
- Appendices 6a and 6b: Maternity Workforce Papers
- Appendix 7: RCOG Locum Audit
- Appendices 8a and 8b: Neonatal Nursing Workforce Summaries
- Appendix 9: Revised and Updated MCoC Action Plan
- Appendix 10: MPOP Tool (Three Year Delivery Plan)

Appendix 1

MWL (Whiston Site): Transitional Care Action plan

Updated October 2025

CNST MIS Safety Action 3 - YEAR 7

Can you demonstrate that you have Transitional Care (TC) services in place to minimise separation of mothers and their babies?

Standard	Actions	Status/Update	Lead	Target Date	BRAG Rating
Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice **or** **Be able to evidence progress towards a NTC pathway from 34+0 in alignment with BAPM TC Framework for Practice and submit this to your Trust & the ODN on behalf of the LMNS Boards.**	***Year 5****: submit business case for Exec approval to enable full implementation of BAPM TC framework for practice*	**At Year 5**, full TC offer not in place and business case in development. **Feb 24**: Business Case approved at Trust Execs for 3.45 WTE B5 neonatal nurses (2.05 already agreed by the Trust) & 5.37 WTE B3 MSW to enable 1 Neonatal Nurse & 1 MSW dedicated to TC each 12-hour shift.	Paediatric Directorate Manager	End Dec 2024	
	Implementation of full TC offer	**Year 6/Oct 24:** On track for implementation of TC by end Dec 2024. **Year 7/Oct 25:** Throughout the year recruitment challenges and pressures due to sickness, mat leave and ongoing HR investigations have resulted in significant workforce gaps which continue, resulting in a delay in commencement of TC. All steps are being taken to manage the absences appropriately and fill gaps. Neonatal Staffing reviewed in Oct 25 using the Neonatal Workforce calculator and submitted to the	Paediatric Directorate Manager/Matron	End Dec 2024	

Standard	Actions	Status/Update	Lead	Target Date	BRAG Rating
		ODN identified staffing deficit based on current activity. A workforce action plan has been developed which will include completion of Nursing Establishment review, development of a staffing business case and completion of a potential cot reconfiguration and associated staffing. Aim is to implement TC by end March 2026.		End March 2026	
	Development and ratification of a new pathway based on the BAPM standards for full implementation of TC	**Year 6/ Oct 24:** Interim SOP for Monitoring of Babies within the Maternity Unit Who Meet the Current Neonatal Transitional Care Criteria including Assessment of Vital Signs using the Newborn Early Warning Score' ratified for use while awaiting full NTC SOP . Draft 'SOP for Neonatal Transitional Care' in development/consultation period prior to presenting for governance approval. **Year 7/Oct 25:** Final SOP for Neonatal Care at Whiston now ratified.	ANNP/TC lead Neonatal consultant lead Whiston/ Ormskirk consultant leads	End of November 2024 June 2025	
		Ready for implementation/adding to intranet once TC launched.		End March 2026	

Standard	Actions	Status/Update	Lead	Target Date	BRAG Rating
		Harmonisation of SOP with Ormskirk NNU to create an MWL TC SOP is ongoing	Whiston/ Ormskirk consultant leads		
	Commencement of recruitment process and appointment of Band 5 Neonatal nurses	**Year 6/Oct 24**: Successfully recruited 3.45 WTE nurses to implement TC. Start date awaited for 1 recruit, all others in post undergoing induction.	Paediatric Matron	Complete	
		Year 7/Oct 25: Although all staff recruited in year 6 and early in MIS year 7, pressures due to sickness, maternity leave and ongoing HR investigations have resulted in significant workforce gaps which remain ongoing and are preventing implementation of TC. Neonatal Staffing reviewed in Oct 25 using the Neonatal Workforce calculator and submitted to the ODN identified staffing deficit based on current activity. A workforce action plan has been developed which will include completion of Nursing Establishment review, development of a staffing business case and completion of a potential cot reconfiguration and associated staffing.	Paediatric Matron	Ongoing	
	Commencement of recruitment process for Band 3 Maternity Support Workers	**Year 6/Oct 24**: MSW recruitment process in progress. 4 MSW in post/undergoing local induction. Additional staff appointed and awaiting start date (2 candidates withdrew/currently back out to recruitment) **Year 7/Oct 25:** All MSW roles for TC recruited and working.	Maternity Matron	End Dec 24	

Standard	Actions	Status/Update	Lead	Target Date	BRAG Rating
	Orientation and training for newly appointed neonatal staff and MSW once employment commenced	**Year 6/Oct 24**: Ongoing for recruited MSWs/ Neonatal Nurses in process of completing online NTC module along with local neonatal competencies. Nursing staff will complete 4-week local induction. **Year 7/Oct 25:** TC study day for neonatal registered nurses is planned for Jan 2026.	Neonatal and Maternity matrons	End Dec 2024 Jan 2026	
	Establishment of process for second checker of IV antibiotics to support NTC nurses.	**Year 6/Oct 24:** Draft 'SOP for Neonatal Transitional Care' in development/consultation period. Efficacy of process to be reviewed 6 months post-launch (including option of upskilling Midwives to be second checkers). **Year 7/Oct 25:** Final SOP for TC states any IVAB required by babies will be prepared and administered by Named Nurse for TC and be second checked by another NNU RN. Exploration of training for MW's to be second checker remains ongoing.	Neonatal and Maternity matrons	End Nov 2024 Ongoing	
	Quarterly TC audits	**Year 6/Oct 24:** QI initiatives include: Quarterly audits continue. Results and learning shared at Clinical Governance meetings. Weekly ATAIN Meetings continue. Learning identified is shared after each meeting in the form of ATAIN Newsletters circulated to medical and nursing staff.	ANNP/TC lead Neonatal consultant lead	Ongoing	

Standard	Actions	Status/Update	Lead	Target Date	BRAG Rating
		Draft 'Guideline for the Management of the Deterioration of the Newborn (NEWTT 2)' in development. **Year 7/Oct 25:** Guideline for the Management of the Deterioration of the Newborn (NEWTT 2) has now been implemented on Maternity. Training in progress for NNU staff in preparation for TC implementation as part of TC Study Day. Weekly ATAIN Meetings continue. Learning identified shared in the form of ATAIN Newsletters circulated to medical and nursing staff.		End Jan 2026	
b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		**Year 6/Oct 24:** Implementation of NEWTT2 registered as a QI project shared with safety champions **Year 7/Oct 25:** NEWTT 2 launched in September 2025	ANNP/TC lead Neonatal Consultant Lead/ Quality and Safety Matron and Midwife	July 2024	
Progress on initiatives must be shared with the Safety Champions and LMNS. **Minimum Evidence Requirement for Trust Board**		**Year 7/Oct 25:** Presentation to TSC and LMNS regarding Implementation of NEWTT 2 in September 2025. Ongoing audits			

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

Appendix 2
MWL (Whiston Site): Fragility of Neonatal Nursing Workforce
Action Plan - November 2025
CNST MIS Safety Action 4 - YEAR 7 MIS

Can you demonstrate an effective system of clinical workforce planning to the required standard?	**Status**	**Actions**	**Lead**	**Target Date**	**BRAG Rating**
The neonatal unit meets the BAPM neonatal nursing standards or if standards are not met, there is an Action Plan with progress against any previously developed action plans and monitored via a Risk Register.	*The neonatal workforce calculator for Q2 25/26 demonstrates that there is a shortfall in the current neonatal workforce based on the activity/acuity on the Whiston neonatal unit and therefore it no longer meets British Association of Perinatal Medicine (BAPM) nurse staffing standards and is non-complaint for CNST MIS Safety Action 4*	Update the Risk Register to reflect non-compliance with BAPM standards and associated patient safety, staffing and resilience risks	Paediatric Matron	Completed Nov 25 (risk rating 15)	
		Pause the implementation of neonatal transitional care based on the need to safely staff the unit, utilising the funded neonatal transitional care establishment	Paediatric Matron	March 26	
		Update LMNS and ODN regarding plan to address non-compliance by developing a business case to increase establishment in line with BAPM standards	Paediatric Matron & Director of Midwifery	Nov 25	
		Develop a business case to increase funded establishment to meet BAPM standards (referring to the most recent Neonatal Workforce Calculator)	Directorate Manager, Matron & Finance Business Partner	Nov 25	
		Complete Cot Reconfiguration Proposal based on activity changes (previously presented to Exec Committee in Jan 2025)	All		
		Report progress monthly through Paediatric Clinical Governance & W&C Divisional Management Group	Paediatric Matron		
		Quarterly progress updates to Trust Board, LMNS and ODN	Paediatric Matron & Director of Midwifery		

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

Appendix 3a

Mersey and West Lancashire Teaching Hospitals NHS Trust

PATIENT SAFETY COMMITTEE

Paper No:

Title of paper: Whiston Maternity Service Quarter 1 2025-2026 Perinatal Board Report

Purpose: To provide a summary of perinatal mortality cases which affected women who were booked for maternity care at Whiston Hospital during Q1 2025-2026

Summary:
In Q1 2025-2026 there were a total of 3 stillbirths including:

- 0 stillbirths that were because of termination of pregnancy.
- 1 term stillbirth
- 0 intrapartum stillbirths.
- 3 Unexpected antenatal stillbirths

(The term still birth was also an unexpected antenatal stillbirth and appears in both categories)

In Q1 the stillbirth rate (excluding TOPFA) is 3.38/1000 births (YTD 3.38/1000 and rolling 12 months 2.81/1000).

Financial Year to date there has been 0 neonatal deaths at Whiston.

In Q1 2025-26 there was no neonatal deaths at Whiston. And no Neonatal deaths of babies following intrauterine transfers of any woman to a regional specialist unit.

There were no cases of concealed pregnancy resulting in pregnancy loss.

There were no PMRT panels held in Q1 without external representation being present. The causes of death, which were for all cases that occurred in Q1 were determined as:

1 Acute on subacute fetal asphyxia
2 Acute placental abruption, fetal vascular malperfusion
3 High grade chronic villitis consistent with villitis of unknown aetiology

An action plan and report are generated following all final PMRT panel reviews. The completion of actions is monitored at the Obstetric and Gynaecology Clinical Governance and Quality Meeting.

Corporate objectives: To achieve 5 Star Patient Care
Financial implications: None
Stakeholders: Staff, the Trust, patients, carers, commissioners will directly benefit or be affected by acceptance of this paper
Recommendation(s): The Committee are requested to note and approve the report
Presenting officer: Sarah Howard
Date of meeting: 19th November

Mersey and West Lancashire – Whiston Quarter 1 2025-2026 Perinatal Board Report

THIS PAPER REPORTS ALL DEATHS IN THAT QUARTER AND THE REVIEWS COMPLETED IN THAT QUARTER FOR THE PREVIOUS QUARTERS DEATHS.

Contents

1. EXECUTIVE SUMMARY .....
2. DASHBOARD AND BENCHMARKING .....
3. MORTALITY REVIEWS AND KEY THEMES .....
4. INTRAPARTUM & TERM STILLBIRTHS .....
5. SAFEGUARDING/UNBOOKED AND LATE BOOKERS .....
6. Q4 NEW CASES SOCIO-DEMOGRAPHICAL .....
7. LANGUAGE BARRIERS .....
8. SAVING BABIES LIVES (V3.0) ELEMENTS .....
9. FETAL ABNORMALITIES DEATHS (known and unknown) .....
10. LEARNING FROM DEATHS .....

PROVIDER: MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST - WHISTON	
COMPLETED BY:	**LISA VEDMORE GOVERNANCE MIDWIFE**
DATE COMPLETED:	

1. EXECUTIVE SUMMARY

In Q1 2025-2026 there were a total of 3 stillbirths including:

- 0 stillbirths that were because of termination of pregnancy.
- 1 term stillbirth
- 0 intrapartum stillbirths.
- 3 Unexpected antenatal stillbirths

(The term still birth was also an unexpected antenatal stillbirth and appears in both categories).

In Q1 the stillbirth rate (excluding TOPFA) is 2.28/1000 births (YTD 1.95/1000 and rolling 12 months 1.95/1000).

Financial Year to date there has been 0 neonatal deaths at Whiston.

In Q1 2025-26 there were no neonatal deaths at Whiston, and no Neonatal deaths of babies following intrauterine transfers of any woman to a regional specialist unit.

There were no cases of concealed pregnancy resulting in pregnancy loss.

At all PMRT panels held for Q1 cases, external representation was present. The causes of death, were determined as:

1 Acute on subacute fetal asphyxia
2 Acute placental abruption, fetal vascular malperfusion
3 High grade chronic villitis consistent with villitis of unknown aetiology

An action plan and report are generated following all final PMRT panel reviews. The completion of actions is monitored at the Obstetrics and Gynaecology Clinical Governance and Quality Meeting.

1 DASHBOARD AND BENCHMARKING

Table. 1 Stillbirths and neonatal death dashboard

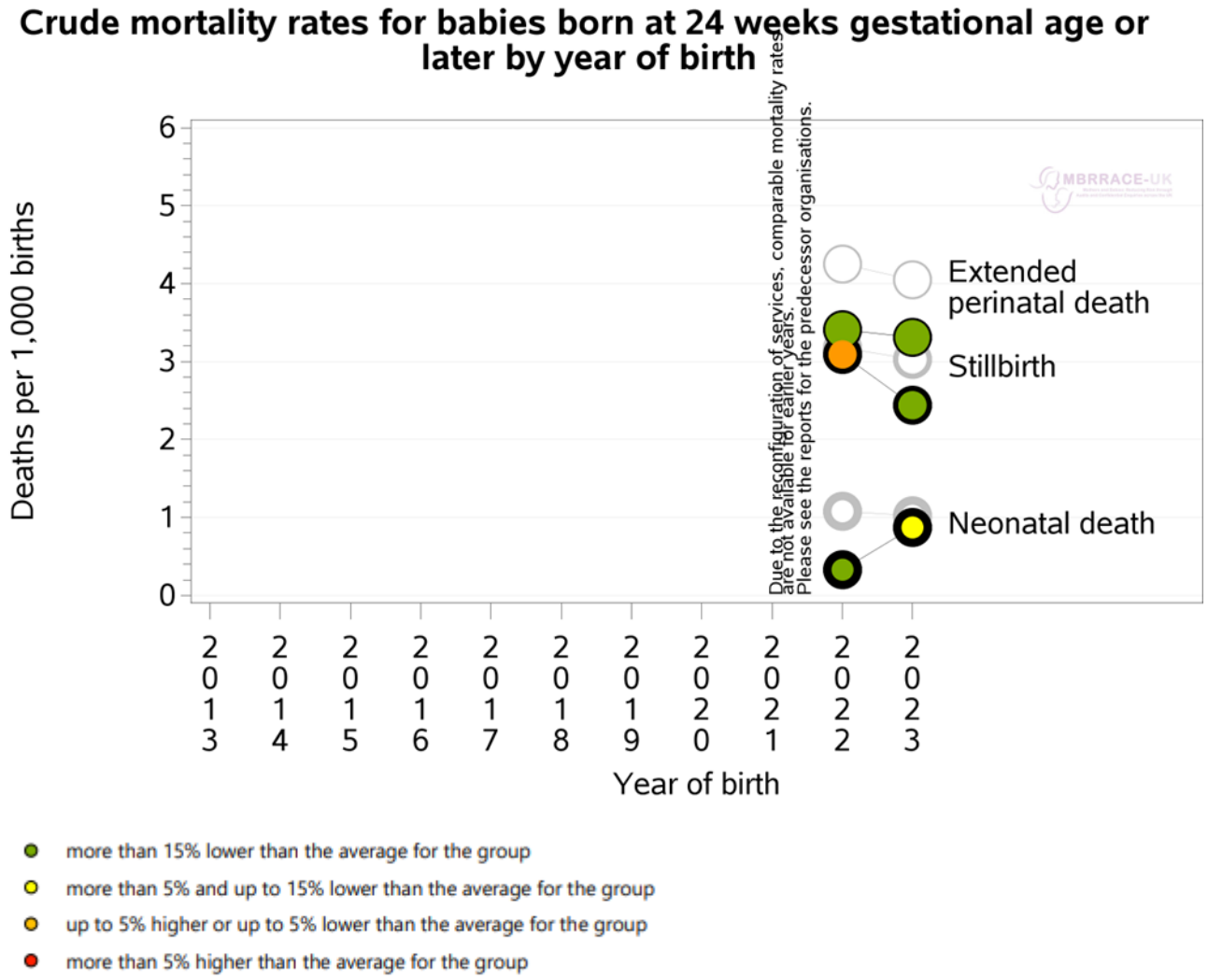
	July-24	August- 24	September-24	October 24	November 24	December 24	January - 25	February - 25	March - 25	April-25	May-25	June-25	TOTAL
Total births	284	302	341	278	307	288	283	261	330	266	314	307	3561
Total stillbirths	3	0	0	1	2	1	0	2	0	0	2	1	12
Stillbirths (excluding terminations)	3	0	0	1	0	1	0	2	0	0	2	1	10
Stillbirth Rate/1000 births	10.56	0	0	3.60	6.52	3.47	0	7.67	0	0	6.37	3.23	3.37
Stillbirth Rate (excluding TOP)/1000	10.56	0	0	3.60	0	3.47	0	7.67	0	0	6.37	3.23	2.81
Total Neonatal Mortality	0	0	0	0	1	0	0	0	0	0	0	0	1
Neonatal Mortality excluding births <22/40	0	0	0	0	1	0	0	0	0	0	0	0	1
Neonatal Mortality Rate/1000 births	0	0	0	0	3.28	0	0	0	0	0	0	0	0.28

In accordance with MBRRACE reporting criteria neonatal deaths are reported by the Trust where the death occurred, regardless of the place of birth. Babies born in this Trust who die elsewhere are also included on the maternity dashboard.

Table 2: Stillbirth (excluding terminations) & Neonatal Mortality Rate per quarter.

Quarter	Stillbirth Rate	NMR
Q2 24/25	3.24	0
Q3 24/25	2.29	1.14
Q4 24/25	2.28	0
Q1 25/26	3.38	0

Fig.1



The above chart is the Crude Mortality rates for Mersey and West Lancashire in comparison to the national average for similar sized trusts for 2023, which is the most recent data produced by MBRRACE.

Table 3: Stillbirth and NN Mortality by cause (Q1 25/26)

Reported cause of death (based on CESDI 2018)	No.	In-utero transfers (IUT)
Stillbirth (causes below)	**3**	**0**
Placenta – Circulatory disorder – other non abruptions other	**1**	
Placenta – Abruption or retroplacental haematoma,in preexisting circulatory disorder	**1**	**0**
Placenta – Villous vascular maldevelopment, Unspecified	**1**	**0**
Neonatal death	**0**	**0**

In Q1 there were 3 Stillbirths. All were Intrauterine fetal deaths antenatally, one was 39 weeks whilst the others were 34 weeks 32+3 weeks gestation.

There were no cases where it was not possible to identify a cause of death.

2 MORTALITY REVIEWS AND KEY THEMES

Table 4. PMRT review panel grading of care provided in cases of Stillbirth

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A	1	3
PMRT grade B	0	0
PMRT grade C	2	0
PMRT grade D	0	0
Total cases	3	3

There were 2 cases where care of the mother and baby up to the point that the baby was confirmed as having died was graded as a C.

The first case where issues were identified was a 32-week gestation antenatal intra-uterine fetal death who was initially booked to receive care at the Ormskirk site. During pregnancy the woman developed gestational diabetes, and the baby was identified as having unilateral

renal agenesis and fetal growth restriction together with raised umbilical artery dopplers. Following seeking an external fetal medicine specialist opinion, the PMRT panel agreed that there were issues that may have made a difference to the outcome of the baby. These were that:

- The management of the pregnancy could have been discussed with a regional fetal medicine centre to clearly plan when the need to expedite delivery would be appropriate, with clear antenatal documentation of parameters in relation to computerised assessment of CTG monitoring and biometry that may indicate this.
- The inconsistent use of interpreting services which may have impacted on the parents understanding of the importance of monitoring and treatment of gestational diabetes and the need for additional fetal monitoring in pregnancy.

The second case graded as a C, for care up to the point where the baby was known to have died, had received all care up to the point of confirmation of the Intrauterine death at another trust, where the mother had chosen to birth. When she was 39 weeks pregnant she experienced reduced fetal movements and sadly the maternity unit at that Trust was experiencing high acuity and was diverting women to other units. Whiston accepted the case to review and, sadly, diagnosed the intra-uterine fetal death on admission.
The PMRT panel identified that, at the Trust who had provided care throughout pregnancy, there were concerns about the baby's growth rate, but these were not acted upon appropriately. The woman had been counselled regarding the reduced growth by a midwife, who had offered an induction of labour, which the woman had declined.
It was noted that the Regional Guideline for the management of Fetal Growth Restriction does not indicate who should counsel a woman when the recommendation is that induction of labour is undertaken at 37- or 39-weeks' gestation, due to growth issues being identified. However, if a woman chooses to decline care within guidelines this should always result in a referral to an obstetrician for further discussion.
The guidance from MBRRACE is that the notification and responsibility for PMRT review is the responsibility of the Trust where the baby dies, regardless of the level of involvement in the pregnancy or birth.

In Q1 2025/26 no stillbirths from previous quarters were reviewed as these had been completed at Q4 PMRT panels.

Table 5. PMRT review panel grading of care provided in cases of Neonatal Deaths

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the baby from birth up to the death of the baby	Care of the mother following the death of the baby
PMRT grade A			
PMRT grade B			
PMRT grade C			
PMRT grade D			
Total cases			

There were no neonatal deaths reviewed in Q1, as no neonatal deaths had occurred. The neonatal death which had occurred in Q3 was reviewed in Quarter 4 24/25.

a. PMRT PANEL ATTENDANCE

The service works to secure external representation for all final panel reviews through liaison with the regional coordinator. In Q1 there was external representation at every panel.

At the final PMRT panels for the stillbirths and Neonatal death the following disciplines were represented:

INTERNAL PANEL MEMBERS

- Consultant Obstetrician
- Governance Midwife
- Senior Midwife
- Bereavement Midwife
- Neonatal Consultant
- Senior Neonatal nurse
- Community Matron
- Quality and Safety Matron

EXTERNAL PANEL MEMBERS

- Consultant Obstetrician
- Neonatal Consultant
- Senior Midwife
- Bereavement Midwife

3 INTRAPARTUM & TERM STILLBIRTHS

There were 0 intrapartum stillbirths in Quarter 1 2025-2026.

There was 1 term stillbirth in Quarter 1 2025-2026.

4 SAFEGUARDING/UNBOOKED AND LATE BOOKERS

There were no cases reviewed at PMRT panels from Q1, that highlighted safeguarding concerns.

5 Q1 NEW CASES SOCIO-DEMOGRAPHICAL

Stillbirth 1
Age 34 at booking
BMI 21.6 kg/m2
White British
Still birth at 39 weeks and 1 day gestation after an induction for fetal death in-utero.

Stillbirth 2
Age 21 at booking
BMI 24.5 kg/m2
Any other Asian background
Stillbirth at 32 weeks and 6 days gestation after an induction for fetal death in-utero.

Stillbirth 3
Age 24
BMI 17.5
White
Stillbirth at 34 weeks and 3 days gestation after an induction for fetal death in-utero.

6 LANGUAGE BARRIERS

There was 1 woman in Q1 where there was language barriers identified in the provision of care.

7 SAVING BABIES LIVES (V3.2) ELEMENTS

Stop Smoking in Pregnancy

In Q1 there were no women who were reported as smokers at booking. There were no issues identified with the care provided for this element.

In one case, who had antenatal care provided by another Trust, until the point of diagnosis of the intra-uterine death, a high CO reading of 5ppm was recorded at booking. This was appropriately acted upon with a referral to the stop smoking team and general advice given around the causes of a high CO reading and home safety.

Management of Small for Gestational Age / Fetal Growth Restriction

Of the three babies born in Q1, 2 babies were small for gestations age (growth between 3rd - 10th centile) and 1 had fetal growth restriction.

1 small for gestational age baby had care appropriate following the maternal risk assessment at booking and there were no issues identified with care.

The other small for gestational age baby reviewed was the case graded as C above, where the growth issues were identified, induction of labour was offered by a midwife and declined. There is no recommendation in the Regional guideline for who should counsel women regarding recommendations for induction of labour. However, the panel agreed that, when a woman declines care within guidance it should result in a referral to an obstetrician for further discussion. The antenatal care in this case was provided at another Trust.

For the baby noted to have fetal growth restriction, the correct assessments and pathways had been implemented that reflect the recommendations in the Regional guideline for detection and management of fetal growth restriction and the SBL Care Bundle. With the management of the case being referred to the Trust Fetal Medicine Team for management.

Reduced Fetal Movements

For all 3 cases in Q1 2025/26 there had been admissions antenatally where the women had reported reduced fetal movements whilst the baby was still alive.

For all 3 cases the appropriate monitoring for the gestations and the level of risk for fetal growth restriction and stillbirth were undertaken when they attended.

All 3 women had received the Tommy's leaflet and where applicable, this was in the correct language.

There were no issues with compliance with this element of the care bundle identified.

Electronic Fetal Monitoring

There were no cases where electronic fetal monitoring in labour was identified as an issue in Q1 2025/26.

Preventing Pre-Term Birth

There was 1 case, in Q1, where the woman presented in threatened Pre-Term labour before the time of a stillbirth.

In this case there was appropriate assessment and implementation of optimisation, prior to her being transferred to a unit with a Level 3 Neonatal service. However, labour did not occur and the woman was returned to the care of MWL.

Management of pre-existing diabetes

There were no cases of unexpected stillbirth or neonatal death that involved pre-existing diabetes that occurred or were reviewed this quarter.

8 FETAL ABNORMALITIES DEATHS (known and unknown)

In one case, in Q1 2025/26 a fetal abnormality was identified.

In this case it was thought that there was unilateral renal agenesis following fetal medicine scans antenatally. However, the postmortem indicated that both kidneys were present however both were 'horse shoe' and one was significantly smaller. The postmortem in this case did not reach any conclusions to the impact of the renal abnormalities on the cause of death.

9 LEARNING FROM DEATHS

The identified areas for learning for the maternity service at MWL in the PMRT panel reviews for cases in Q1 was:

- For complex cases when fetal medicine has identified fetal growth restriction and placental perfusion issues, management can be discussed with the regional specialist team and should be clearly documented in a plan of care. Which should outline parameters within CTG monitoring and biometry that indicate delivery should be considered.
- The importance of correctly implementing the Trust Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard), ensuring that wherever possible a telephone or face to face interpreter is used when the woman's first language is not English. This is of particular importance when complications have developed to ensure that the woman fully understands explanations.

For all cases in Q1 2025 to 2026, the maternity service met the CNST MIS year 7 recommendation that parents should be offered the opportunity to ask questions for review by the PMRT panel. This is achieved through the work of the Bereavement Midwives in supporting the parent's and, to ensure they receive the answers to the questions they are invited to a debrief once the PMRT report is finalised.

Appendix 3b

NHS North West Coast Clinical Networks

Cheshire and Mersey Maternity Quarterly Perinatal Board Report

Mersey & West Lancashire Teaching Hospitals NHS Trust

Ormskirk Maternity Unit

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PROVIDER:	MERSEY & WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST
COMPLETED BY:	**CATHERINE BOYLE MIDWIFE**
DATE COMPLETED:	**08/07/2025**

1. BACKGROUND and INTRODUCTION

The National Perinatal Mortality Reporting Tool has been available for use since March 2018 via the Mothers and Babies: Reducing Risks through Audits and Confidential Enquiry across the UK (MBRRACE-UK) online portal to which the Trust is fully participating in.

The aim is to ensure systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. This will involve a grading of the care provided.

There is active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process and the production of a which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented.

In addition, there is a structured process of review, learning, reporting and actions to improve future care.

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22+0 (or 500g if gestation unknown) to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation (Appendix 1)
- Babies who die in the community 28 days after birth or later who have not received neonatal care
- Babies with brain injury who survive

The Trust / Health Board where the baby died is responsible for leading the review, but all units involved in the care should be part of the review group to ensure that all aspects of the care are considered.

2. EXECUTIVE SUMMARY: Key findings section at the start of report to include

This report details the information in relation to the Perinatal Mortality for Quarters 4 2024-2025 and Quarter 1 2025-2026.

a. *Quarter 4 2024-2025 stillbirth rate (including termination of pregnancy).*

During quarter 4 2024-2025 the stillbirth rate was 2.17 per 1000.

Quarter 1 (2025-2026) stillbirth rate (including termination of pregnancy).

During quarter 1 2025-2026 the stillbirth rate was 0 per 1000.

b. *Quarter 4 2024-2025 neonatal mortality rate.*

- The neonatal mortality rate for quarter 4 2024-2025

  The neonatal mortality rate for Quarter 4 was 2.17 per 1000

  There was one Baby who died at 21+6 weeks gestation

- The neonatal mortality rate for quarter 1 2025-2026.

  The neonatal mortality rate for Quarter 1 was 0 per 1000

3. *Progress on PMRT reports & action plans*

Update on reviews

Quarter 3 (2024-2025)

- Case1: report published.
- Case 2: report published.
- Case 3: report published

Quarter 4 (2024-2025)

In January 2025 there was a neonatal death at 21+6 weeks gestation. This was reported to MBRRACE but does not require review via the PMRT process. A local review took place.

In February 2025 there was one stillbirth at 24+5 weeks following a termination of pregnancy for fetal abnormality. This was reported to MBRRACE but does not require review via the PMRT process.

Quarter 1 (2025-2026)

No cases for review

Quarter 3 2024/2025

Date of Incident	Type of Incident	A/N Care Provider	Date Reported to MBRRACE	Surveillance information	Date PMRT commenced	Date Report Published	Date Parent's Sent
10/10/2024 Date of delivery 12/10/2024	Antenatal IUD at 28+0 weeks	ODGH	14/10/2024	29/10/2024	06/11/2024	28/02/2025	Unable to contact – letter sent
22/10/2024 Date of delivery 23/10/2024	Stillbirth at 38+5 weeks	ODGH	25/10/2024	29/10/2024	04/12/2024	09/04/2025	21/04/2025
04/12/2024	Neonatal death at 36+4 weeks	ODGH	05/12/2024	30/12/2024	08/01/2025	03/06/2025	09/06/2025

Quarter 4 2024/2025

No cases for review

Quarter 1 2025/2026

No cases for review

4. DASHBOARD AND BENCHMARKING

Table. 1 Stillbirths and neonatal death dashboard

	July 2024	*Aug 2024*	*Sept 2024*	*Oct 2024*	*Nov 2024*	*Dec 2024*	*Jan 2025*	*Feb 2025*	*March 2025*	*April 2025*	*May 2025*	*June 2025*	*TOTAL*
Total stillbirths	0	0	0	2	0	1	0	1	0	0	0	0	4
Stillbirths (excluding terminations)	0	0	0	2	0	0	0	0	0	0	0	0	2
Births	195	170	191	186	139	177	158	149	153	180	184	183	2065
Stillbirth Rate/1000 births	0	0	0	10.75	0	5.64	0	6.71	0	0	0	0	
Stillbirth Rate (excluding TOP)/1000	0	0	0	10.75	0	0	0	0	0	0	0	0	
	July 2024	*Aug 2024*	*Seot 2024*	*Oct 2024*	*Nov 2024*	*Dec 2024*	*Jan 2025*	*Feb 2025*	*March 2025*	*April 2025*	*May 2025*	*June 2025*	*TOTAL*
Total Neonatal Mortality	0	0	0	0	0	1	1	0	0	0	0	0	2
Deliveries	194	168	190	184	138	175	155	146	153	177	179	182	2041
Neonatal Mortality Rate/1000 deliveries	0	0	0	0	0	5.71		0	0	0	0	0	

Table 2: Stillbirth (excluding terminations) & Neonatal Death Rate per quarter

Quarter	Stillbirth Rate	NMR
2024-2025		
Q1	1.9	1.93
Q2	0	0
Q3	3.98	2.01
Q4	2.17	2.17
2025-2026		
Q1	0	0
Q2		
Q3		
Q4		

Table 3: Stillbirth and NN Mortality by cause (*Quarter 4 24/25*)

Reported cause of death (based on CESDI 2018)	No.	In-utero transfers
Stillbirth		
Termination of pregnancy for fetal abnormality **1**		
Fetal abnormality		
Pre-eclampsia		
Antepartum haemorrhage		
Medical disorder		
Multiple pregnancy		
IUGR		
Mechanical		
Infection		
Specific placental condition		
Unclassified		
Neonatal death		
Prematurity **1**		

Infection		
Hypoxic ischaemic encephalopathy		
Congenital malformation		
Respiratory		
Abdominal		
Other		

5. MORTALITY REVIEWS AND KEY THEMES

At the PMRT panel review all areas of care are graded for the mother and baby up to the point of antenatal / intrapartum death; following confirmation of the death of the baby; newborn care following the birth up to the death and maternal care following the death of the baby:

- Care of the mother and baby up to the point that the baby was confirmed as having died
- Care of the baby from birth up to the death of the baby
- Care of the mother following confirmation of the death of her baby

Grading

A.	There were no issues with care identified
B.	Improvements in care were identified which would have made NO difference to the outcome
C.	Improvements in care were identified which MAY have made a difference to the outcome
D.	Improvements in care were identified which were LIKELY to have made difference to outcome

Table 4. PMRT review panel grading of care provided in cases of Stillbirth

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A		
PMRT grade B		
PMRT grade C		
PMRT grade D		
Total cases		

0 Quarter 4 2024-2025 cases

0 Quarter 1 2025-2026 cases

Table 4.1. PMRT review panel grading of care provided in cases of Neonatal Death

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the baby up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A			
PMRT grade B			
PMRT grade C			
PMRT grade D			
Total cases			

0 Quarter 4 2024-2025 cases

0 Quarter 1 2025-2026 cases

Table 5. Reasons for review panel grading C&D

Nil applicable

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/Level 1/PMRT with external)	HSIB (yes/no)	Learning	QI plan aligned to theme

a. PMRT PANEL ATTENDANCE

External representatives for the PMRT panels are provided via the Cheshire and Merseyside Safety Collaborative. The Trust has a set timeslot for PMRT meetings the first Wednesday of the month and requests are made for external representation as standard practice via this process.

Where an external Obstetrician is unavailable 2 internal Consultant Obstetricians are present to review. Two internal Senior Midwives are present for every review.

Quarter 4 2024-2025

No cases for Quarter 4

Quarter 1 2025-2026

No cases for Quarter 1

6. INTRAPARTUM & TERM STILLBIRTHS

There was 0 intrapartum stillbirth in Quarter 4 (2024-2025).
There was 0 term stillbirth in Quarter 4 (2024-2025).

There was 0 intrapartum stillbirth in Quarter 1 (2025-2026).
There was 0 term stillbirth in Quarter 1 (2025-2026).

7. TERM NEONATAL DEATHS (in-hospital deaths – for Level 3 units add deaths in Alder Hey)

There were 0 term neonatal deaths in Quarter 4 2024-2025

There were 0 neonatal deaths in Quarter 1 2025-2026.

8. SAFEGUARDING/UNBOOKED AND LATE BOOKERS

Nil applicable cases for Quarter 4 2024-2025 & Quarter 1 2025-2026

9. SOCIO-DEMOGRAPHICAL

Nil applicable cases for Quarter 4 2024-2025 & Quarter 1 2025-2026

10. LANGUAGE BARRIER

Nil applicable cases for Quarter 4 2024-2025 & Quarter 1 2025-2026.

11. SMALL FOR GESTATIONAL AGE

Nil applicable cases for Quarter 4 2024-2025 & Quarter 1 2025-2026.

12. FETAL ABNORMALITIES DEATHS (known and unknown)

Quarter 4 2024-2025

1 -termination of pregnancy for fetal abnormality (ventriculomegaly) at 24+5 weeks

Quarter 1 2025-2026

Nil applicable cases

13. LEARNING FROM DEATHS

Update on learning from reviews in Quarter 3 2024-2025 -all actions completed.

Issue	Action	Implementation plan date
Case 1 Quarter 3 – all actions completed		

Issue	Action	Implementation plan date
Case 2 Quarter 3 – all action completed		

Issue	Action	Implementation plan date
Case 3 Quarter 3 During the review there were improvements in care identified that would not have made a difference to the outcome and some additional lessons learned to improve practice.		
Estimated fetal weights were plotted some of the time	Dissemination of shared learning	03/06/2025
A completed bereavement checklist was not in the notes	Dissemination of the new regional pathway and guideline for Neonatal death	04/04/2025
A referral was not made to the Fetal Medicine Unit in the hospital transferring care to	Dissemination of shared learning	03/06/2025
Delay in home visit for caesarean section wound check	Dissemination of shared learning	03/06/2025

No cases in Quarter 4 2024-2025 or Quarter 1 2025-2026

14. LEARNING / GOOD PRACTICE.

No cases in Quarter 4 2024-2025 or Quarter 1 2025-2026

15. SAVING BABIES LIVES

A review of the key elements of Saving Babies Lives was undertaken to identify learning.

	Case review via PMRT	Smoking in pregnancy a relevant issue	Identification and management of SGA/FGR a relevant issue	Reduced fetal movements a relevant issue	Intrapartum monitoring a relevant issue	Perinatal optimisation / preterm birth a relevant issue	Management of pre-existing diabetes a relevant issue
July to Sept 2024-2025	0	0	0	0	0	0	0
Oct to Dec 2024-2025	3	1	1	1	0	0	0
January to March 2025	0	0	0	0	0	0	0
April to June 2025	0	0	0	0	0	0	0

16. HORIZON SCANNING

As part of intelligence gathering the following sources were used for horizon scanning: CQC, NCEPOD, NHS Digital, NHSE/I (includes LMS), NHSR, PHE, RCOG, RCM, MBRRACE-UK, HSIB, Ockenden, CNST Maternity Incentive Scheme.
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Appendix 4

	Recommendation		Action/evidence required	Responsible Lead	Timescale	Progress	BRAG Rating
Governance and leadership - Programme leadership, management and co-ordination.							
1	Complete the planned work for ANNB screening governance across the whole trust footprint, making sure that ANNB screening is visible to senior leadership and that escalation processes are documented and available for staff	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Organisational structure chart (that is signed off)	DoM, DDoMs	3 Months - July 2025	**Submitted to SQAS on Tuesday 19/8/25**	Rec Closed
			Escalation process (that is signed off)	DoM, DDoMs, Quality and Safety Matrons.		**Submitted to SQAS on Friday 22/08/2025**	Rec Closed
2	Update the terms of reference of the ANNB Steering Group to reflect the trust's joint footprint and include standing agenda items and consistent reporting from all sites, including risks and incident management	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21 2024 - 2025 Antenatal and newborn screening	Terms of reference signed off by the ANNB Steering Group	ANNB Steering Group Chair	3 Months - July 2025	**Submitted to SQAS 27/10/2025**	Pending next meeting for closure confirmation
3	Improve links between maternity and the newborn hearing screening programme to make sure that issues and risks are shared		Escalation process (that is signed off) Minutes from meetings	ANNB Hearing Screening Manager ANNB Steering Group Chair ANNB Hearing Screening	6 months October 2025	**Meeting in place for November**	Pending next meeting for closure confirmation
Governance and leadership - Incident, risk management and escalation							
4	Document the process for the escalation and management of screening incidents (and share this with staff)	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Escalation and management process (that is signed off)	Quality & Safety matron ANNB Screening Coordinators (both sites)	3 Months - July 2025	**Due to be submitted to SQAS by 31/10/2025**	Pending next meeting for closure confirmation
5	Make sure guidelines refer to managing safety incidents in NHS screening programmes and the link to the NHSE screening incident assessment form (SIAF) is updated	Managing safety incidents in NHS screening programmes updated 2024	Guideline (that is signed off)	ANNB Screening Coordinators (both sites) Quality & Safety matrons	12 Months April 2026	*Sent to governance on 13/05/25 for ratification. - CK to double check this is completed across both sites and send to Nicola*	Progressing on schedule
Governance and leadership – Heath Inequalities							
6	Make sure that the screening health inequality audit is presented within the trust and that there is a monitored action plan to address findings	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025	Minutes of meetings Action plan including timescales	ANNB Screening Coordinators (both sites)	6 months October 2025	*Action plan to be submitted as evidence to NP by 10/11/2025*	Progressing on schedule
7	Make sure women have consistent access to translation services for ANNB screening services cross-site. Including when face to face interpreters and telephone translation services are not available and in alternative formats to written information	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025 Antenatal screening pathway requirements specifications 2021	Guideline (that is signed off) which should include how the provider identifies women who need alternative formats to written information. Interpreting services when English is not the first language and neither face to face interpreters or telephone translation services are available. Plan to audit the process within 12 months.	Maternity Matron for Outpatients	12 Months April 2026	Action with AS / LR- Ormskirk requires cordless phones in scan for translation purposes. ?device for telehealth translation services. Karen Lord and Dawn Smith. Sonography guideline / Screening guideline to include detail about use of translation services / provision of written information in alternative formats. Audit scheduled for May 2026 to assess compliance	Progressing on schedule
Governance and leadership – Policies and Guidelines							
8	Make sure that current clinical practice complies with national policy and guidelines, policies and SOPs are appropriately updated to reflect this, including, SCT pathway for abnormal paternal results, updated NIPE pathway for testes, NIPE timeframe for hip scans	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Audit of current clinical practice against guideline. Guidelines (that are signed off)	ANNB Screening Coordinators (both sites)	12 Months April 2026	1. List of requirements from Nicola Poplett 2. List of guidelines across both sites 3. Screening team cross site meeting to develop action plan for guidelines to be merged and updated	Progressing on schedule
9	Make sure harmonised guidelines clearly reflect any site-specific differences and pathways	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Guidelines (that are signed off)	ANNB Screening Coordinators (both sites)	12 Months April 2026	1. List of requirements from Nicola Poplett 2. List of guidelines across both sites 3. Screening team cross site meeting to develop action plan for guidelines to be merged and updated	Progressing on schedule
10	Implement a trust wide governance plan for audit of ANNB screening	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	List of planned audits	Quality & Safety matrons, Maternity Matron for Outpatients	12 Months April 2026	LR to arrange meeting with audit team and create an audit schedule. Audit templates and timescales to be completed and submitted to NHSE as evidence. CK to send list of planned audits to Lorna and Sue,	Progressing on schedule
Governance and leadership – Communication and feedback							
11	Demonstrate that feedback (including complaints) from service users, including those with protected characteristics or from underserved groups is used to develop and/or improve service delivery for antenatal and newborn screening	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	User feedback findings action plan discussed at the ANNB Steering Group	ANNB Screening Coordinators (both sites)	12 Months April 2026	LR to arrange meeting with PALS to establish any current feedback received. LR to work with PALS / MNVP to develop screening specific patient feedback questionnaire if needed.	Progressing on schedule

	Recommendation		Action/evidence required	Responsible Lead	Timescale	Progress	BRAG Rating
Infrastructure – workforce and training							
12	Ensure there is resilience in the service to maintain delivery of screening functions when key members of staff, including the LCO, are absent	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Business continuity plan (that is signed off). Job description/structure chart/guideline that outlines the functions of the respective roles if relevant.	Maternity Matron for Outpatients	3 months July 2025	**Submitted to SQAS 27/10/2025**	Pending next meeting for closure confirmation
13	Make sure there is resilience in the ultrasound service by implementing a collaborative and sustainable workforce plan across all sites, this could also include utilising cross-site training opportunities	Section 7a screening service schedule 2 no: 16 2024 - 2025 Fetal anomaly screening pathway requirements specification 2021	Workforce plan / business continuity plan (that is signed off)	Ultrasound Service Manager	6 months October 2025	Sonography leads to submit by 31/10/2025	Progressing on schedule
14	Implement and monitor a process for ongoing training and continuing professional development for health professionals involved in screening	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Training log / completion of NHS Screening e-Learning resource (with dates)	Maternity Matron for Outpatients ANNB Screening Coordinators (both sites)	12 Months April 2026	Evidence of Screening session as part of midwifery training annual day - Carmel to send agenda, with confimation that it applies across both sites	Progressing on schedule
Identification of cohort (antenatal)							
15	Make sure that weekly checks are in place for the timely identification of the complete antenatal cohort at Ormskirk	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025 Antenatal screening pathway requirements specifications 2021	Tracking process which shows weekly (as a minimum) tracking	ANNB Screening Coordinator Ormskirk site	3 months July 2025	**Carmel sent directly to Nicola 21/8/25**	Rec Closed
16	Make sure processes are documented for the failsafe of the antenatal screening programmes	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025 Antenatal screening pathway requirements specifications 2021	Documented processes (that are signed off)	ANNB Screening Coordinators (both sites)	3 months July 2025	**Confirmation to be given at October board that this is ratified**	Rec Closed
17	Make sure processes are documented for the management of screen positive results for women who miscarry or terminate their pregnancy, and they are followed up as required	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025 Antenatal screening pathway requirements specifications 2021	Documented processes (that are signed off). Tracking system. Letter templates.	ANNB Screening Coordinators (both sites)	6 months October 2025	Letter templates deveolped and added to AN screening guideline, not yet ratified as other amendments also pending.	Progressing on schedule
Sickle cell and thalassaemia screening							
18	Monitor the action plan to meet the acceptable threshold for standard/key performance indicator SCT-S02/ST2 - the proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available before or at 10+0.	Section 7a screening service schedule 2 no: 18 2024 - 2025 Sickle cell and thalassaemia screening pathway requirements specification 2021 Standards 2018 SCT-S02	Action plan that is agreed and monitored by the ANNB Steering Group. Action plan that is agreed and monitored by the ANNB Steering Group.	Maternity Matron for Outpatients ANNB Screening Coordinators (both sites)	12 Months April 2026	LR to discuss with AS current action plan and if needded, plan for identification of root causes for not meeting the acceptable target of 50%	Progressing on schedule
19	Make sure staff providing counselling to women/couples at risk of sickle cell and thalassaemia undertake the accredited genetic risk assessment and counselling module	Section 7a screening service schedule 2 no: 18 2024 - 2025 Sickle cell and thalassaemia screening pathway requirements specification 2021 Standards 2018 SCT-S02	Confirmation of completion of accredited genetic risk assessment and counselling module	ANNB Screening Coordinators (both sites)	12 Months April 2026	CK has now completed GRAC - evidence will be sent to SQAS as soon as module is signed off by KCL	Progressing on schedule
20	Implement a documented process for the fast track of women and/or couples known to be at risk of having a baby with a haemoglobin condition and for women with assisted pregnancies	Section 7a screening service schedule 2 no: 18 2024 - 2025 Sickle cell and thalassaemia screening pathway requirements specification 2021	Documented process (that is signed off)	ANNB Screening Coordinators (both sites)	3 Months July 2025	Draft guideline - NP comments on other aspects of SCT. Appendix 9 - replaced with NHSE pathway	Rec closed

	Recommendation		Action/evidence required	Responsible Lead	Timescale	Progress	BRAG Rating
Infectious disease in pregnancy screening							
21	Improve awareness of staff and the promotion to women of the 'negative now' message in IDPS testing	Section 7a screening service schedule 2 no: 15 2024 - 2025 Infectious diseases in pregnancy screening pathway requirements specifications 2021	Documented process (that is signed off) Minutes of meetings	ANNB Screening Coordinators (both sites)	6 months October 2025	Neg Now messaging now added to training and disseminated through huddles.	Progressing on schedule
22	Make sure that there is an agreed process for the establishment of a formal IDPS MDT when this is required	Section 7a screening service schedule 2 no: 15 2024 - 2025 Infectious diseases in pregnancy screening pathway requirements specifications 2021	Documented process (that is signed off)	ANNB Screening Coordinators (both sites)	6 months October 2025	Both Screening midwives now on regional MDT invite and can attend when Necessary. This will also be reflected in the new IDPS guidelines that are currently unerway	Progressing on schedule
23	Make sure each woman who declines the initial offer of IDPS screening (HIV, Hepatitis B and/or syphilis) is identified, tracked and re-offered screening by 20 weeks of pregnancy or within 2 weeks if booked after 20 weeks gestation	Section 7a screening service schedule 2 no: 15 2024 - 2025 Infectious diseases in pregnancy screening pathway requirements specifications 2021	Documented process (that is signed off)	ANNB Screening Coordinators (both sites)	6 months October 2025	Process to be included in IDPS guidelines with link to AN screening guideline - CK progressing with this guideline	Progressing on schedule
Fetal anomaly screening							
24	Make sure processes are documented including site specific variations across the trust, for booking ultrasound appointments, undertaking a clinical review when a baby is born unexpectedly with on of the physical conditions screened for, IT downteim for maternity ultrasound, induction of new/agency sonographers, ensuring women scanned in EPAU do not miss the opportunity for first Trimester screening.	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Documented processes (that are signed off) including: Booking ultrasound appointments Undertaking a clinical review when a baby is born unexpectedly with one of the physical conditions screened for. IT downtime for maternity ultrasound Induction of new or agency ultrasound staff performing FASP scans Ensure women scanned in EPAU do not miss the opportunity of screening if they are within or approaching the eligible date range for first trimester screening	Screening Support Sonograhpers / Lead sonographers	3 months July 2025	Remaining points outstanding: Lead Sonographer to send New starter induction and Business continuity plan to SQAS - aware of 31/10/2025 deadline Gynaecology matron to include EPAU signposting for pregnant women to book into EPAU SOP. Aware of 31/10/2025 deadline	Behind schedule, expected to be sent by 31/10/2025
25	Make sure the SSS at Whiston is supported in carrying out the functions of the role including capacity to provide feedback on 6-monthly DQASS reports to individual practitioners	Section 7a screening service schedule 2 no: 16 2024 - 2025 Fetal anomaly screening pathway requirements specification 2021 Fetal anomaly screening programme handbook 2024	Rostered time. Feedback to individual ultrasound practitioners.	Ultrasound Service Manager Obstetric Lead sonographer (both sites)	6 months October 2025	SSS will submit an email to SQAS by 31/10/2025, confirmed with Sonography leaders on both sites.	Progressing on schedule
26	Audit the FASP screening pathway including quadruple rate, inadequate samples (FA4) and repeat 20-week scans. The audit should be included on the organisation's audit schedule with an agreed timeline and the findings and associated actions shared into the ANNB Steering Group	Section 7a screening service schedule 2 no: 16 2024 - 2025 Fetal anomaly screening pathway requirements specification 2021 Fetal anomaly screening programme handbook 2024	FASP Audit Schedule. Minutes from ANNB steering group.	Ultrasound Service Manager Obstetric Lead sonographer (both sites)	12 Months April 2026	Audit meeting with maternity data analysts. Karen Lord and Dawn Smith	Progressing on schedule
27	Make sure contact details are updated with National Congenital Anomaly and Rare Disease Registration Service (NCARDRS), that data is submitted timely and all aspects of the process are documented	Section 7a screening service schedule 2 no: 16, 17 2024 - 2025 Fetal anomaly screening pathway requirements specification 2021	Documented processes (that are signed off). Feedback to ANNB Steering Group.	Ultrasound Service Manager Obstetric Lead sonographer (both sites)	3 Months July 2025	Postnatal NCARDRS process now in Screening guideline pending full amendment and ratification	Pending next meeting for closure confirmation

	Recommendation		Action/evidence required	Responsible Lead	Timescale	Progress	BRAG Rating
Diabetic eye screening							
28	Implement and monitor a process to track all eligible women into DESP including women from out of area (Whiston), and report into the ANNB Steering Group	Section 7a screening service schedule 2 no: 22 2024 - 2025 Diabetic eye screening pathway requirements specification 2021	Confirmation of a tracking process Attendance at ANNB Steering Group by DES representative	Diabetic Specialist Midwife (both sites)	3 Months July 2025	**Evidence of tracking process sent to SQAS from both sites by 31/10/2025**	Rec to be closed after meeting with attendence
Newborn hearing screening							
29	Make sure that the NHSP local manager completes outstanding local manager designated tasks and attends the ANNB Steering Group	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021	Confirmation that local manager tasks are up to date Attendence at ANNB Steering Group by local representative	ANNB Hearing Screening Manager (both sites)	3 Months July 2025	LG to send email to NP with confirmation that we are now up to date with management tasks.	Rec Closed
30	Make sure that NHSP processes are fully documented in guidelines and standard operating procedures (SOPs)	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021	Guidelines and policies (that are signed off).	ANNB Hearing Screening Manager (both sites)	12 Months April 2026	SOP's updated and ratified through Bridgewater Board. - Requested for documentation of NHS Number missing in a separate SOP - Laura to discuss with Bridgewater. LG to send once final SOP approved.	Progressing on schedule
31	Make sure aetiological investigation data for babies with PCHI is added onto S4H	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021	Provide updates at ANNB Steering Group	ANNB Hearing Screening Manager (both sites)	6 months October 2025	Audiologist now reactivated - Update of this to also be added as agenda item for next Screening board meeting (October)	Progressing on schedule
32	Implement and monitor a plan to meet the acceptable threshold for standards NHSP-S01 (KPI NH1), NHSP-S02, NHSP-S03 and NHSP-S05 (KPI NH2)	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021 Standards 2022 NHSP-S01 Standards 2022 NHSP-S02 Standards 2022 NHSP-S03 Standards 2022 NHSP-S05	Action plan that is agreed and monitored by the ANNB Steering Group as well as through audiology directorate processes. Submission of data for standard/key performance indicators for NHSP-S01 (KPI NH1), NHSP-S02, NHSP-S03 and NHSP-S05 (KPI NH2).	ANNB Hearing Screening Manager (both sites)	12 Months April 2026	Clinics added which have reduced waiting lists from 60-70 to 20's. LG to add activity completed since visit around clinics into an action plan for presentation at ANNB Screening Board (October)	Progressing on schedule
33	CHIS to make sure that notification of babies with missing results to NHSP is timely to ensure all eligible babies are included and the upper age parameter meets national guidance	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021	Documented CHIS processes, in line with national guidance, for babies with incomplete/no screening results.	Senior CHIS Manager	3 Months July 2025	CHIS evidence submitted via email directly to NP	Rec Closed
Progressing on schedule							
34	Implement and monitor a process to support the continuing professional development of practitioners undertaking NIPE.	Section 7a screening service schedule 2 no: 21 2024 - 2025 Newborn and infant physical examination screening pathway requirements specification 2021 Newborn and infant physical examination programme handbook 2024	Training log / completion of NIPE e-Learning resource each year (with dates).	ANNB Screening Coordinators (both sites)	6 months October 2025	NIPE CPD process developed for discussion at next NIPE working together meeting in November. Guideline also in process, pending discussion at same meeting	Progressing on schedule
35	Implement and monitor a plan to meet NIPE standards NIPE-S02, NIPE-S03, NIPE-S04 (KPI NP4) and NIPE-S05 (making sure that only NIPE defined reportable conditions are documented for referral on S4N)	Section 7a screening service schedule 2 no: 21 2024 - 2025 Newborn and infant physical examination screening pathway requirements specification 2021 Standards 2024 NIPE-S02, NIPE-S03, NIPE-S04/NP4, NIPE-S05	Action plan that is agreed and monitored by the ANNB Steering Group. Submission of data for standard/key performance indicators for NIPE-S02, NIPE-S03, NIPE-S04 (KPI NP4) and NIPE-S05. Quarterly data quality report from S4N.	ANNB Screening Coordinators (both sites)	12 Months April 2026	12 month rec for standards - look at eyes particular - documentation of issues?	Progressing on schedule
36	Audit the process for NIPE referrals to ensure that secondary check by medical staff does not cause delays in the referral pathway	Section 7a screening service schedule 2 no: 21 2024 - 2025 Newborn and infant physical examination screening pathway requirements specification 2021 Newborn and infant physical examination programme handbook 2024	Share audit findings at the ANNB Steering Group Submission of data for standards/key performance indicators for NIPE-S03, and NIPE-S04 (KPI NP4)	ANNB Screening Coordinators (both sites)	6 months October 2025	Audit agreed and registered. Will be completed during November.	Progressing on schedule
Newborn blood spot screening							
37	Implement and monitor a plan to meet the acceptable threshold for standard NBS-S06 (KPI NB2) - the proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process	Section 7a screening service schedule 2 no: 19 2024 - 2025 Newborn blood spot screening pathway requirements specification 2021 Standards 2021 NBS-S06	"Action plan that is agreed and monitored by the ANNB Steering Group Submission of data for standard/key performance indicator for NBS-S06 (KPI NB2)	Maternity Matron for Community Midwifery	12 Months April 2026	LR to follow up with Amy / CK/SA with current action plan	Progressing on schedule
38	CHIS to develop a process to notify GPs of missing NBS results/ unscreened babies at 1 year old	Section 7a screening service schedule 2 no: 19 2024 - 2025 Newborn blood spot screening pathway requirements specification 2021 Standards 2021 NBS-S06	Documented processes (that are signed off)	Senior CHIS Manager	6 months October 2025	CHIS evidence submitted via email directly to NP	Progressing on schedule

Mersey and West Lancashire Teaching Hospitals NHS Trust

Maternity CQC Maternity Ratings - Whiston Hospital	Safe	Effective	Caring	Well-Led	Responsive
	Good	Good	Good	Good	Good

Maternity CQC Maternity Ratings - Ormskirk Hospital	Safe	Effective	Caring	Well-Led	Responsive
	Requires Improvement	Good	Good	Good	Good

	Target	YTD	Sep-25			Aug-25			Jul-25			Jun-25			May-25			Apr-25			Mar-25			Feb-25			Jan-25			Dec-24			Nov-24			Oct-24		
	MWL	MWL	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total
The Number of Incidents Reported Graded as Moderate or Above		9	0	1	1	0	0	0	0	2	2	0	1	1	1	3	4	1	0	1	1	0	1	0	1	1	0	3	3	1	0	1	1	0	1	1	0	1
Healthcare Safety Investigation Branch / Maternity and Newborn Safety Investigations (HSIB/MNSI) / NHS Resolution (NHSR) / CQC or Other Organisation with a Concern or Request for Action Made Directly with Trust	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Coroner Reg 28 Made Directly to Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	No	No	No
Term Admission to NICU from DS		80	9	7	16	8	7	15	7	4	11	7	6	13	13	3	16	6	3	9	11	1	12	9	4	13	13	2	15	5	7	12	6	4	10	7	4	11
Number of StEIS Reportable Incidents / HSIB/MNSI Cases	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	1	1	0	1	1	0	1	0	0	0
Number of Cases Reported to HSIB/MNSI	0	2	0	1	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1	0	0	0
PMRT		7	3	0	3	0	0	0	1	0	1	1	0	1	2	0	2	0	0	0	0	0	0	2	0	2	0	0	0	1	1	2	1	0	1	1	2	3
Number of Intrapartum Stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Neonatal Deaths before 28 days at MWL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	1	0	0	0
Number of Neonatal Deaths before 28 days Elsewhere	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	1	0	1*	1
No Babies Born with HIE Grade 2 +3	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0	0	0	0	0	0	0	0
Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1:1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Supernumerary Shift Co-ordinator	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consultant Delivery Suite Cover (Hrs)			134	74.5		146	74.5		126	74.5		157	74.5		125	74.5	N/A	143	74.5	N/A	128	74.5	N/A	148	74.5	N/A	141	74.5	N/A	98	74.5	N/A	98	74.5	N/A	98	74.5	N/A

Moderate Harm Ormskirk :- Incorrect scoring of VTE as 1, should have been 2. No thromboprophylaxis prescribed. Attended at 6/7 PN with signs and symptoms of DVT which was confirmed on USS.

Case reported to MNSI Ormskirk: 40+3 admitted for possible HIE. Declined by MNSI as normal MRI and no parental or Trust concerns regarding care provided.

Whiston transfers from DS to NNU: Main reason for admission: Respiratory, 6 (66.7%); 1 (11.1%) fetal anaemia; 1 1(11.1%) low Apgar Scores; (11.1%) 1 (11.1%) Low SpO2.

Ormskirk transfers from DS to NNU: Main reason for admission: Respiratory, 6 (85.7%); 1 Therapeutic cooling (14.3%).

PMRT Cases Whiston:
- 38+3/40 High risk at booking. Smoker. Attended maternity triage via NWAS, placental abruption and fetal death in-utero diagnosed.
- 26+2/40 Intermediate risk at Late booking (16 weeks). Smoker. Attended triage with reduced fetal movements and fetal death in-utero diagnosed.
- 39+1/40 Low risk at booking. E-cigarette user. Developed obstetric cholestasis. Attended triage with reduced fetal movements and fetal death in-utero diagnosed.

Whiston Staff Survey Results:	Update Date	Results
Proportion of midwives responding with agree / strongly agree on whether they would recommend Whiston Hospital as a place to work	Oct-22	47%
Proportion of Specialty Trainees in Obstetrics responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours	No data	No data

Ormskirk Staff Survey Results:	Update Date	Results
Proportion of midwives responding with agree / strongly agree on whether they would recommend Ormskirk Hospital as a place to work		
Proportion of Specialty Trainees in Obstetrics responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours	No data	No data

Appendix 6a

Maternity Safer Staffing Oversight Report Q4 2024/25 and Q1 2025/26 (1st January 2025- 30th June 2025) Whiston Site
Purpose: CNST MIS Safety Action 5 requires submission to Trust Board of biannual midwifery staffing oversight report that covers staffing/safety issues (in line with NICE midwifery staffing guidance). The previous report received by the Quality Committee on 18th February 2025. This report provides the continued assurance of safe staffing within MWL Maternity Services between 1st January 2025- 30th June 2025. Included in the report is a breakdown of Birth Rate+ (workforce planning tool for midwifery) and funded establishment for financial year 2/265, demonstrating compliance with outcomes of Birth Rate+ audit received in 2022. Additionally included in the report is the midwife to birth ratio, evidence from the maternity clinical dashboard demonstrating compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one midwifery care in active labour.
Corporate objectives met or risks addressed: Care, Safety, Pathways
Financial implications: None as a direct consequence of this paper.
Stakeholders: The Trust, Staff, Patients
Recommendation(s): It is recommended that the Trust Quality Committee receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.
Report Author: Alison Murray, Divisional Deputy Director of Midwifery Whiston Site

Background

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

Critical to delivering this is the safe, sustainable, and productive staffing in maternity services, NHS boards hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate, and responsive care within available resources (NQB 2016).

NICE 2019 "*Safe Midwifery Staffing for Maternity Settings'* recommendations are for registered midwives (or other authorised people) who are responsible for determining the midwifery staffing establishment. Determine the midwifery staffing establishment for each maternity service (for example, preconception, antenatal, intrapartum, and postnatal services) at least every 6 months. Undertake a systematic process to calculate the midwifery staffing establishment which meets CNST's MIS minimal evidential requirement relating to Safety Action 5 regarding effective midwifery workforce planning.

Birth Rate at Whiston Maternity Site

MWL maternity services utilises scenario-based forecasts based upon the previous years projected births as per national recommendations (NICE 2015). The rationale for utilising projected birth rates to plan for midwifery staffing is to estimate the potential resource impact associated with recommendations regarding midwifery staffing ratios and provide a woman in established labour with supportive one-to-one care that are essential for safe midwifery care.

Births

The number of births at MWL Whiston site between 1st January 2025- 30th June 2025 was 1740 which was a decrease of 60 births (3.3%) from the previous six-month reporting period and a decrease of 4.9% compared to the same reporting period in 2024.

Month	Jan	Feb	Mar	Apr	May	Jun	Total
2025 Births	279	261	326	265	310	302	1743
2024 Births	332	290	329	306	308	268	1833
Variance	-53	-29	-3	-41	2	34	-90

Bookings at MWL Whiston site between 1st January 2025- 30th June 2025 were 1976 which identifies a decrease of 29 bookings (1.4%) compared to the previous six-month period, with a 4.8% decrease compared to the same reporting period in 2024.

Month	Jan	Feb	Mar	Apr	May	Jun	Total
2025 Bookings	357	311	341	309	327	331	1976
2024 Bookings	367	370	336	357	337	309	2076
Variance	-10	-59	5	-48	-10	22	-100

Workforce Planning - BIRTHRATE PLUS® and Maternity Staffing Establishments

The Maternity Incentive Scheme (MIS) Year 7 Safety Action 5 requires that Trusts demonstrate an effective system of midwifery workforce planning. Birthrate Plus® (BR+) is a recognised tool for workforce planning and strategic decision-making.

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

BR+ is the only nationally endorsed tool for calculating maternity staffing levels. The methodology is based on an assessment of clinical risk and the needs of women and their babies during the antenatal period, labour, birth, the immediate post-delivery period, and the postpartum period utilising the accepted safe standard of one Midwife to one woman in labour. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives safe care in labour. BR+ determines the total midwife hours needed and therefore the staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice based on clinical complexity of women who use the service.
Each individual service has their case mix identified using 5 different categories (Cat 1- V) with the lower the score the more normal the processes are for labour and birth and the higher scores indicating when a mother and/or baby require a very high degree of support or intervention. Together with the case mix, the number of midwife hours per patient/client category plus extra midwife time needed for the complicated categories of III, IV & V and calculates the clinical staffing for the annual number of women delivered. Additionally included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

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

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

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

the national trend of intervention as providers have implemented the recommendations of Saving Babies Lives Care Bundle and greater maternal choice.

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

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

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

The below table provides the funded and contracted establishment for the midwives/ MSW providing direct and non-direct clinical midwifery care as of 30th June 2025.

Direct clinical care

Midwives	Funded (WTE)	Contracted (WTE)	Variance (WTE)
Band 7	19.80	22.43	+2.63
Band 5/6	123.26	124.97	+1.18
Band 3 MSW	25.16	23.31	-1.85
Total	**168.22**	**170.71**	**+2.49**

Non-direct clinical care

Midwives	Funded (WTE)	Contracted (WTE)	Variance (WTE)
8 and above	6.00	6.00	0
Band 7/6	8.39	10.19	+1.80
Total	**14.39**	**16.19**	**+1.80**

The BR+ report identified that the required WTE for the provision of direct maternity care was 160.98 WTE with a recommended ratio split between Midwives and Maternity support workers working on the postnatal ward and in community.

The Trust Board has agreed to substantively over establish by 6.00 WTE to cover maternity leave which is maintained, and therefore the maternity funded establishment for the provision of direct midwifery care as of the 30th June 2025 is in line with the recommendations of the BR+ workforce review.

The current funded establishment is 168.22 WTE excluding the externally funded fixed term midwifery posts.

The BR+ report identified that 14.49 WTE is recommended as the staffing requirement for non-direct clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment in 2024/25 is 14.39 WTE but does not include the non-recurrent external funding received for the band 7 posts which are a 0.8 WTE Bereavement midwife, 1.0 WTE preceptorship/ workforce midwife and 0.4 preterm birth midwife which do appear in the contracted posts. There is an expectation of continuation of these roles once external funding is discontinued, and a business case will need to be developed.

The funded establishment for 2024/25 is 182.61WTE which is in line with the recommendations of the BR+ assessment.

Currently the Divisional Director of Midwifery who has a responsibility for Womens and Children's services is included in the non-direct clinical care midwifery staffing, and due to time being allocated for other roles in the portfolio in the new divisional structure and not exclusively for the leadership of midwifery services, the contribution of this post as 1.0 WTE will need to be considered.

The BR+ report analysed data and acuity for the current model of care provided within the Whiston maternity service and did not reflect any future or continuity of carer caseload teams. The maternity service may need to consider utilising the Continuity of Carer deployment tool to assist with determining the required additional number of midwives needed to deliver MCoC at full scale as we progress through the revised MCoC action plan which is currently paused following executive agreement. At present this tool is not endorsed by NHS England.

It is requirement of the MIS that a BR+ assessment is undertaken as a minimum every three years and therefore will be commissioned in 2025 for MWL. This will be the first study that will be commissioned as an MWL Trust and following the TUPE transfer of maternity staffing from Bridgewater Community Trust in 2022. A meeting has been arranged with the BR+ team in September 2025 to discuss MWL requirements.

Maternity Staffing (Planned versus Actual)

Maternity has a process for daily review of planned versus actual staffing. Additionally, twice weekly meetings are held to monitor staffing fill rates and to allocate bank shifts to ensure consistent and safe staffing levels and mitigate staffing shortages.

One of the main service priorities is to maintain safe midwifery staffing levels. Maternity staffing and acuity are assessed on a 4hrly basis by the Maternity Bleep Holder and should staffing fall by the numbers of midwives to provide safe care, the Maternity Escalation Guideline is followed which includes the redeployment of staff. Midwives and MSW undertake a rotational training programme, allowing midwives to rotate between all clinical areas, ensuring a workforce that are skilled to work across all clinical areas of the maternity service. The Maternity Bleep holder consistently reviews staffing with the aim of redeploying non- direct care givers to address periods of high acuity in clinical activity to maintain a safe clinical staffing ratio.

The Maternity bleep holder documentation contains comprehensive accounts of planned versus actual staffing which is completed daily identifying the staffing and activity status.

Any redeployment or escalation is recorded on this documentation. A daily sit rep is also completed by 11am each day and submitted to the LMNS. This identifies current activity, escalation undertaken and hot spots with the ability to request a 'Gold' command meeting and formally request or offer mutual aid to other providers at a system level.

Maternity Workforce Measures

Recruitment

There is an ongoing rolling recruitment programme to address any deficits in vacancies as early as possible and be proactive in covering prospective maternity leave, requests to reduce contracted hours and retirements.

6 Internationally Educated Midwives (IEMs) have joined the Trust since November 22 under the national scheme; however, 2 midwife chose to return home due to personal reasons. All IEMs have required an enhanced level of support and bespoke training plans in addition to the standard orientation and induction plan. All have now progressed to complete their preceptorship and are now working in the clinical numbers as Band 6 Registered Midwives, supported by our workforce and pastoral support midwife, and members of the team.

During Q4/Q1 7.36WTE Midwives commenced in post. This was inclusive of a Deputy Director of Midwifery appointed substantively following a six-month secondment to cover the secondment of the Head of Midwifery to the Director of Midwifery post who also became substantive in this role. Furthermore, there was a realignment of the Midwifery Matron portfolio with existing Matron for Community Midwifery on Whiston site becoming responsible for the MWL Community footprint and the recruitment of Antenatal Service Matron from the Ormskirk funded establishment to work across MWL. This change highlights the future direction of travel and alignment of MWL Maternity services to promote collaborative service leadership and provision.

Proactive recruitment has occurred to ensure those who have been promoted, reduced hours, submitted notice of retirement or are leaving the organisation are being replaced. At the end of Month 3 the service had no actual Midwifery vacancies and 1.85WTE MSW vacancies, however this post was out to recruitment.

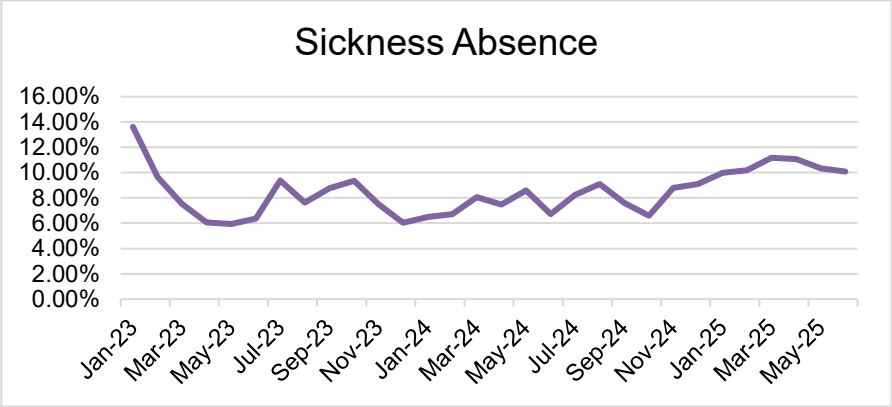
From end of Q4, 0.4WTE Guidelines Midwife post was vacant due to retirement, although supported by a colleague from Delivery Suite in the interim until a review of the Governance Team and realignment of roles has occurred.

Sickness Absence

	Jan	Feb	Mar	Apr	May	Jun
Sickness 2025	9.99%	10.19%	11.18%	11.07%	10.35%	10.08%
Sickness 2024	6.50%	6.71%	8.07%	7.47%	8.58%	6.71%

There has been a reduction in the level of sickness in 2023 since the 13.62% rate in January 2023 for all Maternity staff including Covid-19 related sickness figures, however seasonal fluctuations continue to occur, and sickness remains above trust target of 4.5% which has been allocated as part of the headroom uplift.

It is noted that sickness in Cheshire and Merseyside ICB for Maternity services is higher than other LMNS in 2025 with ongoing review by the regional team.



Sickness and absence management is monitored in accordance with policy supported by HR and HWWB. Divisional sickness reviews continue as does the emphasis on completing return to work interviews. Robust management practice continues, and assurance can be provided that where there is LTS sickness, cases are managed in line with policy with the majority of current LTS cases in the 0–3-month timescale.

Age Profile of Midwifery Staff

The table below indicates the age profile for Midwifery staffing with the largest staff group currently being aged 26-30 years of age. The maternity service had a number of leavers in FY 23/24 due to retirement which has impacted on the experienced skill mix, and subsequent recruitment has employed predominantly newly qualified midwives. More than 50% of the Midwifery workforce are now 40 yrs or younger and therefore it is anticipated that overcoming years we will see a greater impact of maternity leave unavailability on the establishment.

Age Band	Headcount	%
<=20 Years	1	0.38
21-25	15	5.77
26-30	35	13.46
31-35	37	14.23
36-40	44	16.92
41-45	33	12.69
46-50	20	7.69
51-55	25	9.62
56-60	35	13.46
61-65	14	5.38

66-70	1	0.38
Grand Total	**260**	**100.00**

Whilst there is currently an agreement to over-recruit to BR+ recommended establishment by 6.00WTE Midwives, this may need to be reviewed in view of a changing demographic of an entirely female workforce. At the end of Q1 7.64WTE Midwives were unavailable and on maternity leave, with a further 2.44WTE due to commence in Q2.

Quality of Care Measurements

Midwife to Birth ratio

MWL currently use the formula and methodology suggested by BirthRate Plus to produce the calculation. The LMNS have been asked to support in looking at a review across C&M to ensure that the calculation of the midwife to birth ratio is standardised and consistent for all providers, specifically relating to non-direct care giving staff, DS shift coordinators and ward managers and if they are included or excluded in the calculation.

Date	Midwife to Birth ratio
Jan 25	1:25
Feb 25	1:24
Mar 25	1:29
Apr 25	1:22
May 25	1:24
Jun 25	1:24

Supernumerary Shift Coordinator on Delivery Suite

The role of the Delivery Suite Shift Coordinator is a key role in the intrapartum area and are present 24/7 and are a recommendation within the Ockenden Report. The Delivery Suite Coordinator is supernumerary which is a pivotal role to enable them to undertake their role effectively in providing an overarching view, effective leadership, clinical expertise and facilitating communication between professionals whilst overseeing appropriate use of resources. The shift co-ordinator is rostered independently from the core midwifery staffing, and this is evidenced in e-roster with a distinct marker against the shift coordinator indicating supernumerary status.

Date	Supernumerary Shift Coordinator
Jan 25	100%
Feb 25	100%
Mar 25	100%
Apr 25	100%
May 25	100%
Jun 25	100%

One to One Care in Labour

Safe Staffing for Maternity Setting (NICE 2015) stipulates that care should be provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same Midwife for the whole of labour). Compliance is monitored monthly on

the maternity dashboard and compliance for the period was 100% and there have not been any occurrences where this has not been achieved in the previous 12 months.

Date	One to One Care in Labour
Jan 25	100%
Feb 25	100%
Mar 25	100%
Apr 25	100%
May 25	100%
Jun 25	100%

Midwifery Red Flag Events

NICE Safe Midwifery Staffing guidance recommends utilising nationally recognised red flag indicators.

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

The following are the recommended red flags which require documenting via the Datix Incident Reporting System.

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (e.g., diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 15 minutes or more between presentation and triage (BSOTS)
- Delay of 30 minutes or more between presentation and triage
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Red Flag Event	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Total
Delayed or cancelled time critical activity	0	0	0	0	0	0	**0**
Missed or delayed care	0	0	0	0	0	0	**0**
Missed medication	0	0	0	0	0	0	**0**
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	**0**
Delay of 15 minutes or more between presentation and triage	8	12	2	0	2	1	**25**

Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	**0**
Delay of 2 hours or more between admission for induction	0	2	0	0	0	0	**2**
Delay in transfer to delivery suite for ARM	0	0	0	0	0	0	**0**
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**
Any occasion when 1 Midwife cannot provide continuous 1:1 care in labour	0	0	0	0	0	0	**0**

There were 27 Midwifery Red Flags reported in Q4/Q1, 25 which related to a delay in 15 Minutes or more from presentation to triage, and 2 related to delay of 2 hours or more from admission to induction. The national reporting standard Red Flag is a woman to be triaged within 30 minutes of attending the maternity unt, but as a maternity service we have chosen to reduce this to the 15 minutes as recommended within BSOTS (Birmingham Symptom specific Obstetric Triage System) which in line with Cheshire and Mersey LMNS providers as a local Midwifery Red Flag.

Red Flag delays reported in relation to attendance to commencement of induction of labour both occurred when women were booked to attend Delivery Suite directly from home, and due to high acuity at the time, commencement of induction was delayed in order for midwives to continue to appropriately prioritise the provision of continuous 1:1 midwifery care. Induction was commenced as soon as practicable, and apologies offered to the women.

All delays in triage were due to a high acuity and capacity and numerous women attending simultaneously. Following targeted training in 2025 around how to address and seek clinical support when simultaneous attendances occur, the department initially saw an increase in red flags which represented an improved reporting culture, allowing the identification of themes and trends, but this has now reduced as systems and processes regarding escalation have now been embedded within the department. The new central telephone system has had a positive impact in ensuring all calls are answered with appropriate support and action taken at times, however an emerging theme of high volume of calls alongside triage breaches has been highlighted in the analysis and is being monitored by the department leads

The Red Flags are all incident reported, and any learning from Red Flag incidents is disseminated via ward meetings, safety huddles and the Obstetrics & Gynaecology Clinical Governance & Quality meetings.

All midwifery red flags were reviewed by the Clinical Lead and Matron for the area and there were no additional incidents related to these delays in undertaking triage or commencement of induction, and no harm occurred.

Continuity of Carer

Whiston developed revised plan for the delivery of a Maternity Continuity of Carer model in line with delivering ‘Maternity Continuity of Carer Model at Full-Scale’ guidance which

identified that a whole new model of care is required utilising a mixed risk model providing enhanced midwifery care to women and babies of Black, Asian and mixed ethnicity and those living in the 10% decile of deprivation, which has previously been submitted to Quality committee, Trust Board and to the LMNS in 2022.

The current homebirth team provides full continuity of care to women once a decision has been made to birth at home which can be undertaken at any stage of a woman's antenatal pathway. The amethyst team continues to provide continuity to the most vulnerable women although they are currently unable to provide the intrapartum element of the model currently with the intrapartum support coming from the Delivery suite.

Following the formation of MWL the current MCoC position and expansion at both legacy sites is currently on hold which has previously been agreed at Board level. The Maternity service formally began to align community Midwifery services across MWL footprint in readiness for a whole scale re-review of the plans for MCoC as part of Community Midwifery Matron portfolio in April 2025. During the alignment and wholescale review of the MCoC plan as an MWL maternity service the current MCoC teams from the legacy organisations will remain operational.

The BR+ report reflects the current traditional model of care and does not provide any recommendations for the delivery of CoC. A full review using the National CoC workforce tool will be required to determine what additional staffing will be required to fully implement CoC, however this tool is not currently endorsed by NHSE as evidence based.

Summary

The number of births at MWL Whiston site between 1st January 2025- 30th June 2025 was 1740 which was a decrease of 60 births (3.3%) from the previous six-month reporting period and a decrease of 4.9% compared to the same reporting period in 2024. However, it is important to not see the activity as numbers alone and recognise increasing complexities and shifts in case mix of women with increasing induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and identified that 14.49 WTE is the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment is 14.39 WTE and aligns to the recommendations.

The non-direct clinical care band 7 posts include three fixed term externally funded posts (2.2WTE) which are included in the contracted figures but not in the funded establishment and a business case will be required the expectation is that these posts will be substantive once the external funding ends.

The BR+ report concluded that the required WTE for the provision of direct maternity care was 160.98 WTE and the current funded establishment is 168.22 WTE due to changes following TUPE transfer and inclusive of an agreement to establish by substantively an additional 6.0 WTE to cover maternity leave.

The funded establishment for 2024/25 is 182.61WTE which is in line with the recommendations of the BR+ assessment.

It is requirement of the MIS that a BR+ assessment is undertaken as a minimum every three years and therefore should be commissioned in 2025 for MWL. This will be the first study that will be commissioned as an MWL Trust and following the TUPE transfer of maternity staffing from Bridgewater Community Trust in 2022. A meeting has been arranged with the BR+ team in September 2025 to discuss MWL requirements

The service operates an ongoing rolling recruitment programme to reduce any deficits in vacancies as early as possible and be proactive in covering prospective maternity leave and retirements. end of Month 3 the service had no actual Midwifery vacancies and 1.85WTE MSW vacancies, however this post was out to recruitment

Headroom for the service is currently factored at 22%. This is inclusive of annual leave, sickness; however, this may need to be revisited in view of the increasing demand on the requirements of maternity safety training.

It was agreed to over establish by 6.00WTE Midwives to cover maternity leave. This may need to be revisited in view of a changing workforce demographic of an entirely female workforce.

Midwife to Birth ratio is between 1:22 and 1:29. The LMNS have been requested to review how this is calculated to ensure consistency across Cheshire and Mersey providers and consistent benchmarking.

There has been 100% compliance noted for the provision of one-to-one care in labour and the availability of a supernumerary Delivery Suite shift coordinator for this six-month reporting period.

In the six-month period there were 27 Midwifery Red Flag events reported, which was a decrease from previous reporting period. All were reviewed by the Clinical Lead and Matron for the area and there were no additional incidents related to these delays in undertaking triage and no harm occurred.

Appendix 6b

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Corporate objectives met or risks addressed: Care, Safety, Pathways
Financial implications: None as a direct consequence of this paper.
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Recommendation(s): It is recommended that the Trust Quality Committee receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.
Report Author: Dawn Meredith, Divisional Deputy Director of Midwifery Ormskirk Site

Background

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

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Birth Rate at Ormskirk Maternity Site

MWL maternity services utilises scenario-based forecasts based upon the previous years projected births as per national recommendations (NICE 2015). The rationale for utilising projected birth rates to plan for midwifery staffing is to estimate the potential resource impact associated with recommendations regarding midwifery staffing ratios and provide a woman in established labour with supportive one-to-one care that are essential for safe midwifery care.

Births

Month	Jan	Feb	March	April	May	June	Total
Q4 2024 and Q1 2025 Births	158	148	153	180	184	183	1006
Q4 2023 and Q1 2024 Births	174	192	189	176	182	161	1074
Difference per month	-16	-44	-36	+4	+2	+21	-68

Month	July	Aug	Sept	Oct	Nov	Dec	Total
Q2-Q3 2024 Births	195	170	191	186	139	177	1058
Q2-Q3 2023 Births	180	180	173	171	158	174	1036
Difference per month	+15	-10	+18	+15	-19	+3	+22

Bookings

Month	Jan	Feb	March	April	May	June	Total
Q4 2024 and Q1 2025 Bookings	186	177	206	211	194	215	1189
Q4 2023 and Q1 2024 Bookings	229	195	203	220	192	187	1226
Difference per month	-43	-18	+3	-9	+2	+28	-37

Month	July	Aug	Sept	Oct	Nov	Dec	Total
Q2-Q3 2024 Bookings	199	197	194	222	234	175	1221
Q2-Q3 2023 Bookings	227	206	200	204	178	191	1206
Difference per month	-28	-9	-6	+18	+56	-16	+15

Workforce Planning - BIRTHRATE PLUS® and Maternity Staffing Establishments

The Maternity Incentive Scheme (MIS) Year 7 Safety Action 5 requires that Trusts demonstrate an effective system of midwifery workforce planning. Birthrate Plus® (BR+) is a recognised tool for workforce planning and strategic decision-making.

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

Birthrate Plus is a framework for workforce planning based on an understanding of the total midwifery time required to care for women with a minimum standard of the provision of one-to-one midwifery care to women throughout their established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Birthrate Plus® is the only nationally endorsed tool for calculating maternity staffing levels. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during the antenatal period, labour, birth, the immediate post-delivery period and the postpartum period utilising the accepted standard of 1 Midwife to 1 woman in labour. This determines the total midwife hours needed and therefore the staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice.

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

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

S&OHT	% Cat I	% Cat II	% Cat III	% cat IV	% Cat V
2021 DS % case mix	4.1%	14.1%	23.6%	27.5%	30.7%
2018 DS % case mix	4.1%	14.1%	30.8%	23.2%	27.8%

The most recent BR+ report was completed on 9th January 2022 and was based on the births and forward bookings for 2020/2021 which was 2387 births. The recommendation for the funded establishment for the provision of direct midwifery care included a 25% uplift for annual leave, sickness, and study leave.

The Maternity funded establishment for the provision of direct midwifery care at the time of this staffing report is above the recommendations of the 2022 Birthrate plus assessment. Following publication of the report and a serious incident within the Maternity service the Trust Board agreed to increase the funded establishment by 5.55 WTE to provide separate cover for elective caesarean section lists, increased training as a result of Ockenden followed by a number of externally funded posts.

A staffing review in 2023 also resulted in increasing the funded establishment for direct midwifery care to include an average uplift representative of the last 3 years annual leave, sickness, training, and maternity leave as per Ockenden essential safety action one. The previous uplift for midwifery staffing of 25%, was subsequently increased to 30%.

The below table demonstrates the funded and contracted establishment for the midwives providing direct and non-direct clinical midwifery care.

Direct care

Midwives	Funded establishment	Contracted
Band 7	17.14	16.75
Band 5/6	92.97	84.24
Band 3 MSW	5.28	5.28
Total	115.39	106.27

Non direct clinical care

Senior management and specialist midwives	Funded establishment	Contracted
8 and above	5.00	3.9
Band 7	10.12	10
Band 5/6	0.7	0.1
Total	15.82	14

The above band 7 posts include 4.2 wte externally funded band 7 posts which are a 0.4wte additional hours for the Bereavement midwife, 1wte preceptorship/workforce midwife, 0.2wte pre-term birth and multiple pregnancy midwife, 1wte digital midwife (funded by Digital

transformation team for 12 months from 1st July 2024) and 1 wte Smoking Cessation midwife. In addition, there is 0.6wte externally funded band 6 hours for MSW retention.

The BR+ report identified that 9.51wte is recommended as the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical whole time equivalent (wte). The current funded non-direct care equates to 15.82wte. It is noted a slight decrease from the previous biannual staffing paper, due to a review of the direct and non-direct hours component of specialist midwives' roles and therefore a redistribution of non-clinical hours to clinical hours was adjusted. The contracted establishment is currently 14wte and below the funded establishment due to vacancies for 1.1wte matron, (Retirements) and vacancies for 0.12 infant feeding midwife and a band 6 MSW retention midwife.

The current funded establishment relates to 12% of the total clinical establishment which is above the BR+ recommendations of 9% and is due to additional funding from Ockenden and externally funded posts.
The Matron vacancy has been recruited to and 1wte Maternity Outpatient Matron is due to commence on 28th July covering maternity outpatients at both Whiston and Ormskirk sites.

The additional staff include the provision of cover for elective caesarean section lists, increased training due to Ockenden recommendations alongside 3.6 wte band 7 externally funded posts which include 1wte smoking cessation midwife, 0.4wte bereavement midwife, 1wte preceptorship/ workforce midwife, 0.2wte pre-term birth/ multiple pregnancy midwife and 1wte band 7 digital midwife secondment in place to support the implementation of the new electronic maternity system funded via the digital transformation monies. There is also a 0.6wte Band 6 midwife for MSW retention vacancy.

The report concluded that the required whole time equivalent for the provision of direct maternity care was 107.89wte which included a 25% uplift for annual leave, sickness, and study leave based on the births which was 2387 and forward bookings for 2020/2021.

The funded clinical midwife establishment for the reporting period is 115.39wte inclusive of 5.28wte MSW's. This is a positive variance of 7.5wte to the birthrate plus recommendation due to the 30% uplift, designated staff for elective caesarean lists and some externally funded posts.

The staffing position at the end of June 2025 identified that the unit was not in deficit to the BR+ funded establishment recommendations for the maternity workforce based on our current modelling ratio of midwife to MSW.
The total workforce requirements based on BR+ recommendations was 117.40wte and the current funded establishment is 131.21wte.

The current vacancy is 9.1wte across all clinical midwifery posts with band 5 and 6 due to commence by October 2025 (the recruitment has taken into consideration midwives who have given notice of reduced hours or are expected to leave prior to December 25) which will result in zero vacancies anticipated once all staff commence employment.

The BR+ report highlights the required additional support for Band 2 support workers whose roles are essential to the service but are not included in the midwifery ratio calculations, the requirement for these support staff to be decided by professional judgement. Currently there are sufficient band 2 and 3 support workers working across the service to provide support for midwives however, there was a deficit of 1wte band 3 on the maternity assessment unit. This has been recruited to with the MSW due to start in August.

The BR+ report analysed data and acuity for the current model of care provided within SOHT, whilst staffing for BSOTS was included it did not reflect any other future plans or continuity of carer caseload teams. To progress MCoC the maternity service would need to utilise the National Continuity of workforce tool to determine the required additional number of midwives needed to deliver MCoC at full scale as progress is made through the revised MCoC action plan.

There is an ongoing rolling recruitment programme in an attempt to address any deficits in vacancies as early as possible and be proactive to cover prospective maternity leave and retirements.

The Maternity Inpatient Matron and Preceptorship Midwife have revised the pathway for band 5 midwives to support an earlier transition to band 6 for those that are ready at around 12 months. Preceptorship midwives are now rotating 3 monthly to aid expediated experience across the service.

Maternity Staffing (Planned versus Actual)

Maternity has a process for daily review of planned versus actual staffing. Additionally, meetings are held to monitor staffing fill rates and to allocate bank shifts if required to ensure consistent and safe staffing levels and mitigate staffing shortages.

A 24/7 maternity bleep holder is available who is a senior midwife of Band 7 and above who has oversight of the staffing and clinical activity and oversees any redeployment as required which includes members of the Senior Management Team, Specialist Midwives and utilisation of the escalation process as required to maintain a safe clinical staffing ratio. The bleep holder is an additional role 07:30-20:00hrs with the Delivery Suite shift coordinator covering the bleep 19:30-08:00hrs. The Maternity bleep holder documentation is completed 4 times per day and contains documentation of planned versus actual staffing which is completed daily identifying the staffing and activity status. Any redeployment or escalation is recorded on this documentation by the bleep holder. A daily Sit rep is submitted at 08:30hrs which is discussed at patient flow meetings within the acute Trust. A daily C+M sit rep is also completed by 11am each day and submitted to the LMNS. This identifies current activity, escalation undertaken and hot spots with the ability to request a ‘Gold’ command meeting and formally request or offer mutual aid.

Plans to review to the maternity bleep holder at Ormskirk are in place to consider the shift leader role supernummary across 24hours.

Sickness

	Jan	Feb	Mar	Apr	May	Jun
Sickness	**5.18%**	**6.4%**	**4.93%**	**5.13%**	**6.12%**	**5.23%**

Over the past 6 months Midwifery sickness levels have varied between 5.13% and 6.4%. There have been no trends to the sickness with the majority being due to short term sickness. Staff shortages have been mitigated by offering extra shifts and bank hours. However, as recruitment has increased and become closer to the full establishment funded figure the need for bank shifts has reduced. Maternity staffing and activity are monitored frequently every day with staff being redeployed to the clinical area of greatest need.

Sickness and absence management is monitored in accordance with policy supported by HR and HWWB. Divisional sickness reviews continue as does the emphasis on completing return to work interviews. Robust management practice continues, and assurance can be provided that where there is LTS sickness, cases are managed in line with policy with the majority of current LTS cases in the 0–3-month timescale.

The maternity service utilises E roster for staffing which is monitored daily by the maternity managers, matrons and roster co-ordinator to identify and deficits in actual staffing compared to planned staffing.

A 24/7 maternity bleep holder is available who is a senior midwife of Band 7 and above who has oversight of the staffing and clinical activity and oversees any redeployment as required which includes members of the Senior Management Team, Specialist Midwives and utilisation of the escalation process as required. The bleep holder is an additional role 07:30-20:00hrs with the Delivery Suite shift coordinator covering the bleep 19:30-08:00hrs. The Maternity bleep holder documentation is completed 4 times per day and contains documentation of planned versus actual staffing which is completed daily identifying the staffing and activity status. Any redeployment or escalation is recorded on this documentation by the bleep holder. A daily Sit rep is submitted at 08:30hrs which is discussed at patient flow meetings within the acute Trust. A daily C+M sit rep is also completed by 11am each day and submitted to the LMNS. This identifies current activity, escalation undertaken and hot spots with the ability to request a 'Gold' command meeting and formally request or offer mutual aid.

Plans are under review to extend the maternity bleep holder at Ormskirk to a role additional to the shift leader across the 24hours.

Midwife to birth ratio

Month	Ratio
Jan 2025	1:22.25
Feb 2025	1:22.09
March 2025	1:21.61
April 2025	1:21.37
May 2025	1:21.34
June 2025	1:22.5

MWL currently use the formula and methodology suggested by BirthRate Plus to produce the calculation. The LMNS have been asked to support in looking at a review across C&M to ensure that the calculation of the midwife to birth ratio is standardised and consistent for all providers, specifically relating to non-direct care giving staff, DS shift coordinators and ward managers and if they are included or excluded in the calculation.

The midwife to birth ratio recommended by Birthrate plus was 1:22.6.

Continuity of Carer

The Trusts current position for Continuity of carer remains on hold pending evaluation of the community service across MWL by the community Matron at Whiston broadening her portfolio across sites. The Sapphire Team, our current CoC team was launched in 2017 and has remained fully operational. The Team consists of 7.96 WTE midwives providing

antenatal, parent education, hypnobirthing, intrapartum and postnatal care for women living outside the West Lancs area but choosing to deliver at ODGH, there are 4 teams of 2 midwives located at Children's centres, their caseload calculated at 1:36 Working pattern: 9-5 community days and long day/night on Delivery suite to provide intrapartum care for women booked under the care of the team.

Data January to June 2025

METRIC	Jan	Feb	Mar	Apr	May	Jun
% of women at 29 weeks on a CoC pathway	**8.5%**	**10.3%**	**7.3%**	**9.6%**	**10.8%**	**10.9%**
% of Asian, Black or Mixed women at 29 weeks on a CoC pathway	**0%**	**10%**	**0%**	**0%**	**0%**	**0%**
% of women in bottom decile of deprivation at 29 weeks on a CoC pathway	**18.2%**	**14.3%**	**8.8%**	**23.7%**	**21.1%**	**13.6%**

Age Profile of Midwifery Staffing

The table below indicates the age profile for midwifery staffing with 41.58% of staff being aged between 46 and 60. However latest data shows that following the recruitment of staff in 2024 there has been a shift across the age range resulting in a more even spread across the ages of 21-60 with a minority of staff now 61 and over.

Age Band	% of Staff
21-25	**8.75%**
26-30	**7.29%**
31-35	**8.75%**
36-40	**19.7%**
41-45	**5.83%**
46-50	**17.51%**
51-55	**6.56%**
56-60	**17.51%**
61-65	**7.29%**
66-70	**1.46%**

The changes to the NHS pension scheme have led to an increase in midwives over 55 wishing to access their pension fund and remain in work on reduced hours. With the majority of new staff being under 35 this retention has helped to maintain an even spread of age and subsequently experience.

One to One Care in Labour

Safe Staffing for Maternity Setting (NICE 2015) stipulates that care should be provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same Midwife for the whole of labour). Compliance is monitored monthly on the maternity dashboard and compliance for the period January to June was 100%.

Midwifery Red Flag Events

NICE Safe Midwifery Staffing guidance recommends utilising nationally recognised red flag indicators.
A midwifery red flag event is considered as a potential early indicator warning sign. These incidents must be reported to the maternity shift leader to identify and address and identify any immediate actions.
The following are the recommended red flags which require documenting via the Datix incident reporting system.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or Midwifery-Led Unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 Midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

An Inphase report is completed if there are any occasions that the DS shift coordinator is unable to maintain a supernumerary status. Red flags are also reported on the Birthrate+ acuity tool which is completed 4hrly on Delivery Suite.

Theme	Total for Q4 2024/25 &Q1 2025/26							
	Jan	Feb	Mar	Apr	May	Jun	Total	
Delayed or cancelled time critical activity	0	0	0	0	1	0	**1**	
Missed or delayed care	0	0	0	1	0	0	**1**	
Missed medication	1	1	0	1	0	0	**3**	
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	**0**	
Delay of 15 minutes or more between presentation and triage	0	0	2	0	0	1	**3**	
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	**0**	

Theme	Total for Q4 2024/25 &Q1 2025/26							
	Jan	Feb	Mar	Apr	May	Jun	Total	
Delay of 2 hours or more between admission for induction	1	2	2	2	2	1	**10**	
Delay in transfer to delivery suite for ARM	2	2	2	0	1	0	**7**	
Delayed recognition of and action on abnormal vital signs	0	0	0	1	0	0	**1**	
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	0	0	0	**0**	
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0	**0**	
TOTAL	**4**	**5**	**6**	**5**	**4**	**2**	**26**	

At Ormskirk there were 26 red flags in total during Q4 and Q1. The red flags were across the 6 months period with the highest number being 10 in the delays of 2 hours or more between admission for induction and starting the process. This was predominantly due to the number of women requiring induction.
There were 7 red flags relating to delay in transfer to Delivery suite for continuation of the induction of labour process by ARM which were due to acuity on Delivery suite.
Maternity bleep holders were sent a reminder to consider mutual aid if transfer to delivery suite is unlikely after 12 hours.
3 incidents were reported due to delays of 15 minutes or more between presentation and Triage. The national reporting standard Red Flag is a woman to be triaged within 30 minutes of attending the maternity unit as outlined by NICE, but as a maternity service we have chosen to reduce this to the 15 minutes as recommended within BSOTS (Birmingham Symptom specific Obstetric Triage System) which in line with Cheshire and Mersey LMNS providers as a local Midwifery Red Flag. All patients were seen within the 30-minute target set by NICE. There were no harms reported for any of these incidents.
There were 3 incidents of missed medication. All red flag incidents are discussed at the Maternity patient safety meeting and the Maternity lead pharmacist attends this meeting weekly to discuss any medication errors or red flags.

The red flags are all reported via Inphase, and any learning from red flag and Inphase incidents are disseminated via ward meetings, safety huddles and the Maternity Governance and Quality meetings.

Supernumerary Shift Coordinator on Delivery Suite

The role of the Delivery Suite Shift Coordinator is a key role in the intrapartum area and are present 24/7 and are a recommendation within the Ockenden Report. The Delivery Suite Coordinator is supernumerary which is a pivotal role to enable them to undertake their role effectively in providing an overarching view, effective leadership, clinical expertise and

facilitating communication between professionals whilst overseeing appropriate use of resources. The shift co-ordinator is rostered independently from the core midwifery staffing, and this is evidenced in e-roster with a distinct marker against the shift coordinator indicating supernumerary status
Inability to maintain supernummary status is a red flag. No red flags have been reported in this reporting period due to compliance.
A monthly audit is also undertaken which has confirmed 100% compliance to the Shift Coordinator being supernumerary and is presented at the Maternity Governance meeting. The maternity bleep holder documentation has a section to confirm at the minimum 6 hourly walkabouts that the shift leader is supernumerary and in the event that this was not achieved a narrative and rationale as to the reason for non-compliance.

Summary

Births within Ormskirk Maternity for the period January to June 2025 was 1006 which is a decrease of approximately 11 births per month compared to the average of the previous 6 months. Bookings for the 6-month period were 1189, for comparison this is a decrease in bookings of 6 per month compared to the previous 6 months. However, it should be note that birthrates fluctuate year to year.

The Birthrate plus report identified that the DS case mix was that 58.2% of women are in the 2 highest categories of care required which is in line with the average for England of 58%. which is an increase of 7% from the previous Birthrate plus assessment in 2018. This reflects the increase in induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The total workforce requirements based on BR+ recommendations was 117.40wte and the current total funded establishment is 131.21wte and is above the recommendations of BR+.

9.51wte (9% of total clinical time) is recommended BR+ establishment for non-direct staff The current funded non-direct care equates to 15.82wte (12% of the total clinical establishment) which is above the BR+ recommendations and is due to additional funding from Ockenden and externally funded posts.

BR+ recommended that the required whole time equivalent for the provision of direct maternity care was 107.89wte which included a 25% uplift for annual leave, sickness, and study leave based on the births which was 2387 and forward bookings for 2020/2021.
The actual funded clinical midwife establishment is 115.39wte inclusive of 5.28wte MSW's. This is a positive variance of 7.5wte compared to the birthrate plus recommendation due to the 30% uplift, designated staff for elective caesarean lists and some externally funded posts.

The service operates an ongoing rolling recruitment programme to reduce any deficits in vacancies as early as possible and be proactive in covering prospective maternity leave and retirements. end of Month 3 the service had no actual Midwifery vacancies and 1.85WTE MSW vacancies, however this post was out to recruitment

All vacancies have been recruited to and are in the recruitment phase with 7.3 newly qualified midwives due to commence by October 2025 which has taken into consideration midwives who have given notice of reduced hours or are expected to leave prior to December 25). This will result in zero vacancies anticipated once all staff commence employment.

The Department is currently in the process of rotating band 2 maternity care assistants to Delivery suite which will enable two band 3 maternity support workers to be rostered each shift on Maternity ward.

The BR+ report does not reflect any future plans for the service or continuity of carer caseload teams.

The maternity service currently has additional midwives in post/ under recruitment that are funded by the LMNS or NHSE with an expectation of continuation of these roles which include a workforce/ preceptorship midwife and bereavement midwife which were not included within the BR+ workforce report.

Over the past 3 months Midwifery sickness levels have reduced further to an average of 5.49%. Staffing is monitored daily; the use of NHS professionals bank is utilised to cover deficits. Nonclinical midwives are utilised if staffing and acuity indicate insufficient staffing.

A 24/7 maternity bleep holder is available who has oversight of the staffing and clinical activity and overseas any redeployment as required which includes members of the Senior Management Team, Specialist Midwives and utilisation of the escalation process as required. The bleep holder role is separately staffed 07:30-20:00 and held by the Delivery Suite Shift Coordinator overnight.

There has been 100% compliance noted for the provision of 1-1 care in labour and the availability of a supernumerary Delivery suite shift coordinator for this 6-month reporting period.

Between January and July 2025 there were 26 Midwifery red flags events. The majority of these were for due delays in commencing induction and for transfer to Delivery Suite for the next stage of induction. Delays of 15 minutes or more between presentation and triage have remained low with only 3 red flags over the 6 months.

There have been no maternity diverts requested over this reporting period.

It is requirement of the MIS that a BR+ assessment is undertaken as a minimum every three years and therefore should be commissioned in 2025 for MWL. This will be the first study that will be commissioned as an MWL Trust and following the TUPE transfer of maternity staffing from Bridgewater Community Trust in 2022. A meeting has been arranged with the BR+ team in September 2025 to discuss MWL requirements

Appendix 7

Mersey and West Lancashire Teaching Hospitals NHS Trust

Project MatUnitCA20252026 - 65
Audit of RCOG Locum Checklist

Michelle Bull
Temporary Staffing Team Lead

Date: September 2025

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1. BACKGROUND

As evidence for MIS year 7, this audit was undertaken in respect of Safety action 4, measuring against RCOG guidance on the engagement of short and long term Obstetric and Gynaecology locum doctors on tier 2 or 3(middle grade) rotas.

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

Required Standard a) Obstetric medical workforce.

1.1: Audit of short-term locums.

The Trust must ensure that any locums undertaking short-term employment (2 weeks or less) must meet one of the following criteria.

a) Currently works in their unit on tier 2 or 3 rota
   or
b) Have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progressions (ARCP)
   or
c) Hold a certificate of eligibility (CEL)to undertake short-term locums

1.2: Audit of long- term locums.

The Trust should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS board.

2. AIMS & OBJECTIVES

Requirement for 100% compliance for standards for short term and long-term locums including 100% compliance against the RCOG checklist

3. STANDARDS

Compliance Level	RAG rating
90-100%	
70-89%	
<69%	

4. METHODOLOGY AND FINDINGS

Short term locums

The audit for employment of short-term locums was undertaken from 1st Feb – 31st August.

For this reporting period there were 24 Short term locums who undertook shifts on the tier 2 and 3 rotas with the following compliance:

Locum currently works in their unit on the tier 2 or 3 rota	0/24
OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progression (ARCP)?	0/24
OR c) Hold a certificate of eligibility (CEL)to undertake short-term locums	24/24(100%)

All locums were compliant in accordance with the RCOG guidance providing 100% compliance by all meeting requirement c of holding a certificate of eligibility (CEL)to undertake short-term locums.

Long term locums

A six-month audit is required after February 2025 until 30th November 2025. The MWL audit was undertaken for the period 1st February to the 31st August 2025 inclusive.

The audit identified that there was no long term locums employed during this reporting period and therefore there is no requirement to provide evidence of monitoring and compliance with the RCOG tool.

5: MWL Process for recruitment of locums

-Medic Bank onboarding is completed by the MWL Recruitment Team for both External and Internal applicants.

-Agency Doctor recruitment is managed through the Medic Temporary Workforce Team via Plus us and Patchwork Agency Manager.

The Trust has a robust process and guidance for advertising vacancies, recruiting and checking of eligibility, GMC registration and compliance requirements which includes:

- Vacancies are advertised on Patchwork Agency Manager (PAM) for S&O and Plus us (STHK) this includes details of the area of work, Site & Unit, hours of work, Grade of Doctor, specialist skills and departmental specific details such as a job plan are also added.

- Prospective Doctors are proposed by the Agency on PAM / Plus Us this must include the CV and compliance pack as detailed under the conditions of the NHSi Agency recruitment framework- HealthTrust Europe: Total Workforce Solutions III

- For Bank booking The Roster Co-Ordinator reviews all proposals checking the CV, Compliance Pack and GMC registration against the requirements for the vacancy.

- For Agency The Medic Temporary workforce administrator reviews all proposals checking the CV, Compliance Pack and GMC registration against the requirements for the vacancy.

- If shortlisted, the CV and compliance pack are sent for approval to the Clinical Lead for the Specialist Area, requesting when approving, that the CL states the Doctors Grade and whether the Dr is suitable for working on call shifts.

- Further contact can be arranged between the proposed Dr and the CD to discuss the vacancy requirements.

- Once the CV is approved the booking is confirmed in PAM / Plus us

- For STHK The Roster Co-Ordinator will complete a sostenuto request for IT Access, Clinical systems Training and Access for the date Doctor commences.

- For S&O The Medic Temporary Workforce administrator will complete a sostenuto request for IT Access, Clinical systems Training and Access for the date Doctor commences.

- The Doctors details are entered onto the Health Roster system by the Temporary Workforce Team detailing the GMC registration, Date clinical systems is completed and the Unit preference for CV approvals.

- Date of commencement – The Doctor is inducted by The Clinical Team with the Consultant on Call named as Supervisor.

- All other compliances are managed by the Agency, who are responsible for updating PAM under the conditions of the NHSi Agency recruitment framework - HealthTrust Europe: Total Workforce Solutions III

Audit findings of process compliance

	Compliance Short Term Locums
Compliance pack and CV in Patchwork system	100%
Locum Doctor CV reviewed by consultant lead prior to appointment	100%
Discussion with Locum doctor re clinical capabilities by consultant Lead prior to starting or on appointment	100%
Departmental Induction by Consultant on commencement date	100%
Access to all IT Systems, guidelines and Training completed on commencement date	100%
Named consultant Supervisor to support Locum	100%
Supernumerary Clinical duties undertaken with appropriate direct supervision	Not applicable
Review of suitability for post and OOH Working based on MDT feedback	100%
Feedback to locum doctor and agency on performance	Not applicable

5: Conclusion

A 100% compliance rate for MWL employing short term locums in accordance with the RCOG guidance with all medics having a certificate of eligibility.

There were no long term locums employed within MWL for this reporting period and therefore 100% compliance.

100% compliance with the employment process checks and support for short term locums

6. Recommendation

In terms of the booking process, we are currently operating on several different systems but the compliance check list and principles remain the same. The process is being reviewed in order to align the systems.

REFERENCES

Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales: Available at rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf (accessed 25th November 2024)

APPENDIX 1

Royal College of Obstetricians & Gynaecologists

Monitoring of compliance/effectiveness

The RCOG/NHS recommends that units monitor compliance with this guidance.

The following is a simple tool which can be adapted for local use and retained as evidence of a robust process of assessment for all locum appointments. This could be completed by the lead consultant with support from a medical administrator

Compliance	Completed Y/N	Date
Locum doctor CV reviewed by consultant lead prior to appointment		
Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment		
Departmental induction by consultant on commencement date		
Access to all IT systems and guidelines and training completed on commencement date		
Named consultant supervisor to support locum	Name:	
Supernumerary clinical duties undertaken with appropriate direct supervision		
Review of suitability for post and OOH working based on MDT feedback		
Feedback to locum doctor and agency on performance		

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Appendix 8a

Neonatal Nursing Workforce Summary: Whiston

INPUT UNIT DETAILS			
Trust	Mersey and West Lancashire Teaching		
Unit	Whiston		
Designation	LNU		
Completed by	Janet Bentham		
Date completed	20.10.25		
Activity period **Start date:**	01/04/24	**End date:**	31/03/25
	HRG 1 (IC)	**HRG 2 (HD)**	**HRG 3-5 (SC)**
Activity by care level	132	694	3269
Comissioned cots by care level	0	2	13

DIRECT PATIENT CARE - *DO NOT INCLUDE ANY NON-DIRECT PATIENT CARE WTE*				
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**
Sister / Charge Nurse	7	0.4	0.4	1
Deputy Sister / Charge Nurse or Senior Staff Nurse	6	11.92	10.93	15
Staff Nurse QIS	5 QIS	4.67	4.67	6
Subtotal QIS Nurses		**16.99**	**16**	**22**
Staff Nurse NON QIS	5 NON QIS	7.48	7.09	
Subtotal Non QIS Nurses		**7.48**	**7.09**	**0**
Subtotal - Registered Nurses		**24.47**	**23.09**	**22**
Nursing Associate	4	1.53	1.53	2
Trainee Nursing Associate		0	0	0
Nursery Nurse	4	1.84	0	0
Healthcare Support Worker	3	3.48	3	
Subtotal - Other direct patient care staff		**6.85**	**4.53**	**2**
TOTAL DIRECT PATIENT CARE		**31.32**	**27.62**	**24**

ADDITIONAL NEONATAL UNIT DATA - *NURSES WORKING ON NEONATAL UNIT ONLY*				
	From	**To**	**WTE**	**Head Count**
New Starters	01/07/2025	30/09/2025	0	0
Leavers	01/07/2025	30/09/2025	1	1
Net Gain / Loss	01/07/2025	30/09/2025	**-1**	**-1**
Turnover (%)	01/07/2025	30/09/2025	**0%**	**0%**
Current vacancies (WTE)	01/07/2025	30/09/2025	**6.15**	
Current maternity Leave (WTE)	01/07/2025	30/09/2025	0.61	
			WTE	**Hours used**
Sickness in quarter	01/07/2025	30/09/2025	**8.0**	3922.75
Bank Usage in quarter	01/07/2025	30/09/2025	**2.8**	1382.75
Agency Usage in quarter	01/07/2025	30/09/2025	**0.2**	84

The below table has been autopopulated based on the previous quarter; please kindly check and update this table for the current quarter as required
Check the box to confirm that the data has been reviewed for Q2 ☐

NON DIRECT PATIENT CARE - *DO NOT INCLUDE ANY DIRECT PATIENT CARE WTE*					**COMMENTS**
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**	*e.g. no dedicated hours, data not available / not collected*
LEADERSHIP ROLES					
Consultant Nurse		0			
Senior/Lead Nurse		0			
Matron		1	1	1	
Ward Manager		0.6	0.6	1	
Recruitment & Retention Lead		0			
Other Senior role (please specify)		0.4	0.4		
Subtotal - Leadership roles		**2**	**2**	**2**	
QUALITY ROLES					
Governance Lead Nurse - Band 7		0			
Practice Development / Education Lead - Band 7		0			
Clinical Educator		1	0	2	
Infant Feeding Lead		0			
Family Integrated Care Lead / equivalent		0			
Family Integrated care Nurse / equivalent		0			
Family Integrated Care Link Nurse		0			
Other Family Care (please specify)		0			
Bereavement Lead		0			
Palliative Care Lead		0			
Professional nurse advocate (PNA)		0			
Other (please specify)					
Other (please specify)					
Other (please specify)					
Subtotal - Quality roles		**1**	**0**	**2**	
TOTAL NON DIRECT PATIENT CARE		**3**	**2**	**4**	

TRANSITIONAL CARE NURSING STAFF - Neonatal Nurse staff only					**COMMENTS**
Role Title	**Band**	**WTE Budget**	**WTE in post**	**Head Count in post**	*e.g. data not available / not collected*
Transitional Care Lead	7	0			
Transitional Care Neonatal Nurse	6	0			
Transitional Care Nurse	5	3.45	2	2	NTC not commenced yet
Transitional Care Nursing Associate	4	0			
Transitional Care Nursery Nurse	4	0			
Transitional Care Non-registered		0			
Subtotal - Transitional Care		**3.45**	**2**	**2**	
OUTREACH NURSING STAFF					
Outreach Lead		0			
Outreach Registered Nurse - Band 6	6	0			
Outreach Registered Nurse - Band 5	5	0			
Outreach Nursery Nurse	4	0			
Outreach Non-Reg (please specify)		0			
Subtotal - Outreach Nursing staff		**0**	**0**	**0**	
TOTAL NURSING WORKFORCE		**37.77**	**31.62**	**30**	

ENHANCED AND ADVANCED NEONATAL NURSE PRACTITIONER DATA				
	Band	**WTE Budget**	**WTE in post**	**Head Count in post**
Enhanced Neonatal Nurse Practitioner (ENNP)				
Senior ANNP				
ANNP				
Trainee ANNP				

ALLIED HEALTH PROFESSIONALS, PSYCHOLOGISTS & PHARMACISTS - *INCLUDE IN PATIENT WTE ONLY*						
	Band*	**WTE Budget**	**WTE in post**	**Head Count in post**	***Required WTE***	***Variance - in post againsts required WTE***
Dietitian	7	0.2	0.2	1	**0.53**	**-0.33**
Pharmacist					**0.48**	**-0.48**
Physiotherapist	7	0.32	0.32	1	**0.75**	**-0.43**
Occupational Therapist					**0.75**	**-0.75**
Speech & Language Therapist	7	0.65	0.65	1	**0.70**	**-0.05**
Psychologist	8a	0.2	0.2	1	**0.75**	**-0.55**

**Use multiple rows to capture where multiple bands for each occupation*

Neonatal Nursing Workforce Tool (2020): Whiston

Unit details			
Trust	Mersey and West Lancashire Teaching Hospitals NHS Trust		
Unit	Whiston		
Designation	LNU		
Completed by			
Date completed			
Activity period	01/04/24	to 31/03/25	365 days

Activity (HRG 2016)		
	Activity	Commissioned cots
HRG 1 (IC)	132	0
HRG 2 (HD)	694	2
HRG 3 - 5 (SC)	3,269	13
Total	**4,095**	**15**

Staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	16.99	16.00
Total Non QIS	7.48	7.09
Total Non Reg	6.85	4.53
Total	**31.32**	**27.62**

Activity calculations (HRG 2016)							
	Activity	*For calculations*		Commissioned cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	132	*0.5*	*6.07*	0		1	-1
HRG 2	694	*2.4*	*3.04*	2	95.07%	2	0
HRG 3	3,269	*11.2*	*1.52*	13	68.89%	12	1
Total	**4,095**			**15**	**74.79%**	**15**	**0**

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 31.87, of which 22.31 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	31.32	27.62	33.02	-1.70	-5.40
Total reg nurses	24.47	23.09	27.92	-3.45	-4.83
Total QIS	16.99	16.00	19.54	-2.55	-3.54
Total non-QIS	7.48	7.09	8.38	-0.90	-1.29
Total non-reg	6.85	4.53	5.10	1.75	-0.57
Reg nurses as % nursing staff	78.1%	83.6%	84.6%		
QIS as % reg nurses	69.4%	69.3%	70.0%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependency care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

Neonatal Nursing Workforce Tool (2020): Ormskirk

Input unit details			
Trust	Mersey and West Lancashire Teaching Hospitals NHS Trust		
Unit	Ormskirk		
Designation	LNU		
Completed by	Shirley Coward		
Date completed	20/10/25		
Activity period	Average 2022/23, 23/24 & 24/25	Days in period	365

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	109	1
HRG 2 (HD)	544	1
HRG 3 (SC)	1,819	8
Total	**2,472**	**10**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	22.20	14.60
Total Non QIS	0.00	6.60
Total Non Reg	1.76	2.56
Total	**23.96**	**23.76**

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	109	*0.4*	*6.07*	1	29.86%	1	0
HRG 2	544	*1.9*	*3.04*	1	149.04%	2	-1
HRG 3	1,819	*6.2*	*1.52*	8	62.29%	6	2
Total	**2,472**			**10**	**67.73%**	**9**	**1**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 27.32, of which 19.12 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	23.96	23.76	23.44	0.52	0.32
Total reg nurses	22.20	21.20	20.61	1.59	0.59
Total QIS	22.20	14.60	14.43	7.77	0.17
Total non-QIS	0.00	6.60	6.18	-6.18	0.42
Total non-reg	1.76	2.56	2.84	-1.08	-0.28
Reg nurses as % nursing staff	92.7%	89.2%	87.9%		
QIS as % reg nurses	100.0%	68.9%	70.0%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

NURSING QUALITY ROLES

Role Title	Band	WTE Budget	WTE in post	Ideal	Difference budget v ideal	Projected cost*
LEADERSHIP ROLES						
Senior/Lead Nurse					0	
Matron	8a	1	1	1.00	0.00	£58,487.00
Ward Manager	7	1	0.96	0.80	-0.2	£40,218.40
Other Senior role (please specify)					0	
QUALITY ROLES						
Governance Lead Nurse*	7			0.25	0.2472	£12,427.49
Practice Development/Education Lead*	7	1	1	1.00	0	£50,273.00
Clinical Educator	6				0	£0.00
Infant Feeding Lead	7	0.2	0.2		-0.2	£0.00
Family Integrated Care Lead	7	0	0	0.49	0.4944	£24,854.97
Family Integrated Care Nurse					0	
Other Family care/developmental care role					0	
Bereavement/Palliative Care Lead	7	0	0	0.25	0.2472	£12,427.49
Professional Nurse Advocate (PNA)					0	
QI in perinatal optimisation lead					0	
Safeguarding Children					0	
Discharge Planning role					0	
Infection control lead					0	
ENNP					0	
Other						
Neonatal Digital Nurse	7			1.00		£50,273.00
Totals		3.2		4.79	0.59	£248,961.34
Direct Nursing shortfall						£0.00
Total nursing workforce (headcount)	33					
Birthrate	2031					

* It is not a requirement to provide the projected cost, but it is advisable to complete the local costing, as you may be asked for this at short notice if any further funding becomes available.

* 0.1WTE/1,000 care days

* This is 1WTE per 50 members of staff, if less than 50 staff in total minimum of 1 WTE required

* 0.2WTE/1,000 care days

* 0.1WTE/1,000 care days

Mersey and West Lancashire Teaching Hospitals NHS Trust

Appendix 9

Maternity Continuity of Carer Action Plan
Revised and Updated September 2025

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

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

		Action	Responsible person	Expected date of Completion	Progress	BRAG
15		IT support to extract analyse and provide data on which to base the MCOC teams. I.e postcode linked to areas of deprivation and ethnicity.	BI analyst	September 2026		
16		Ensure that 75% of BAME women and women from the most deprived 10% of areas are prioritised into a MCoC team.	Community matron	September 2026	Formal align community Midwifery services across MWL footprint in readiness for a whole scale re-review of MCoC.	
17		Determine the provision of an enhanced model of MCoC that provides extra support for women from the most deprived 10% of areas	Community matron	September 2025	Fusing received for 1.6WTE Midwifery support worker posts on a fixed term basis to support teams working in the most deprived areas across MWL. Awaiting advertising.	
18		Midwifery deployment plan into MCoC, to facilitate a phased scale up to default position of care whilst maintaining safe staffing levels	DoM/DDoMs / Maternity Matrons	August 2026		
19		Realignment of Maternity rosters	E – Resourcing Team leader/ Maternity Matrons	September 2026	Establishment reviews to be completed following BR+ assessment. In the interim MWL community midwifery services have been aligned and are under review for team allocations as one service in readiness for BadgerNet.	
20		Implement 4 MCOC teams	Community Matron	September and October 2023	On Hold as per National Review	
21		Ensure co production of action plan with MVP	DoM/DDoMs	September 2026		
	Training					
22		Revise mandatory training programme to include MCOC updates	Practice development midwife	August 2026		
23		Training programmes to share best practice and build confidence managing mixed risk caseloads	Practice development midwife	August 2026		

		Action	Responsible person	Expected date of Completion	Progress	BRAG
24		Each midwife, core and MCoC team midwives will have a personal training needs analysis programme based on findings of the competency assessment framework which will identify any clinical skills needed to provide care for women throughout the pregnancy journey and across a range of settings, and also for providing care to women from diverse ethnic backgrounds and those living in the most deprived communities.	Maternity managers/ matrons	September 2026		
25		Plans to be developed to identify and allocate the time and resources needed to upskill midwives who are required to work in unfamiliar environments.	Maternity matrons	ongoing		
26		Consider use of a buddy scheme and PMA role to support staff	Maternity matrons	January 2023		
	Communication and Engagement					
27		Agree long and short term communication plans for all stages for transformation including: - Updating staff on progress - Celebrate benefits of MCoC model for staff and women - Sharing feedback from staff and women under the care of MCoC teams - Utilisation of use of social media. - Continued engagement with Maternity Voice Partnership to raise awareness, obtain feedback and co design patient information - Newsletters - Information on Trust website	DoM/DDoMs and Clinical Director	September 2026		
28		Develop GP communications and agree content with GP forums and CCG/ ICS	Clinical Director	October 2026	Previous engagement but updates required once MCoC has been reviewed and Trust plans agreed.	
29		Develop regular maternity service communication meetings / briefings/ workshops and communication blog	Maternity matrons/ comms team	July 2026		

		Action	Responsible person	Expected date of Completion	Progress	BRAG
30		Develop regular meetings with MCOC teams	Maternity matrons	September 2026		
31		Development of patient information leaflets	Maternity matrons/ MVP chair	September 2026		
32		Liaison with staff side	DoM/DDoMs Maternity matrons	July 2026	Reinstatement of meetings with staff side and HR once Trust position agreed.	
33		Consider requirement for staff consultation in order to fully implement MCoC	Head of Midwifery	July 2026		
	Skill Mix					
34		Develop a MCoC competency assessment	Practice development midwife /Maternity matrons	Sept 2026		
35		Identify individual gaps in experience, knowledge and skills for individuals utilising the competency assessment framework with individual meetings	Practice development midwife /Maternity matrons	June 2026		
36		Devise personal development plans in place for all Midwives allocated to a MCoC team or core team	Practice development midwife /Maternity matrons	June 2026		
37		Ensure preparedness of Band 7 DS coordinators to support programme of change with workshops and engagement sessions	Maternity matrons	June 2026		
38		Development of an orientation package for new MCoC teams and new team members	Maternity matrons	June 2026		
39		Ensure appropriate use of Maternity support workers.	Maternity matrons	October 2026	Review of MSW responsibilities in community once recruitment complete	
	Team building					

		Action	Responsible person	Expected date of Completion	Progress	BRAG
40		Time for team building once teams established	Maternity matrons	September 2026 and continuing		
	Linked Obstetrician					
41		Agree named link Consultants for each MCoC Team	Clinical Director	September 2026		
42		Ensure a robust referral process to an obstetrician process Is in place	Clinical Director	Completed	Current processes in place which will be updated prior to the implementation of the new teams and allocated linked consultants	
	Standard Operating Procedure					
43		Development of an SOP that outlines roles and responsibilities to support delivery of MCoC.	Quality and Safety Matron	September 2026		
	Governance					
44		Risks will be identified and managed within the Trust Governance Framework with the development of a risk log	Quality and Safety Matron	ongoing		
45		Development of an MCoC SOP	Quality and Safety Matron	September 2026		
46		Review escalation policy in view of implementation of MCoC	Quality and Safety Matron	September 2026		
47		Evaluation of the process of availability of data collection and reporting mechanism	Digital midwives	September 2026		
48		Ensure process for extraction of MSDS National Data Collection is appropriate	Business Intelligence manager	July 2026		
	Pay					
49		Utilise the MCoC toolkit to review midwifery pay for staff working in a MCoC team as no midwife should be	DoM/DDoMs/ Senior	June 2026		

		Action	Responsible person	Expected date of Completion	Progress	BRAG
		financially disadvantaged in a MCoC as identified in the NHSE/I toolkit	management accountant			
50		Work with staff, HR and unions to agree on appropriate uplift or on call payments, considering LMNS wide agreement where appropriate or possible with presentation to the Board for consideration.	DoM/DDoMs	June 2026		
	Estates and Equipment					
51		Identify initial numbers and cost of additional equipment required for staff working in a MCOC team based on full rollout being mindful that additional teams may be required dependant on WTE of midwives allocated per team.	Community matron	June 2026		
52		Identify and source suitable clinical venues required for the provision of MCoC within the community environment as midwifery care will not be in GP practices	Community matron	September 2026	Provision of Lowe House but further estates needed across MWL.	
53		Ensure adequate IT systems and connectivity are fit for purpose to enable appropriate off site access	IT project manager	September 2022		
	Review Process					
54		Quarterly review of action plan by Trust Board	DoM/DDoMs	June 2026	Via Quality Committee Paper	
55		Determine LMNS and national action plan review dates	LMNS CoC lead			

Objective	Deliverables	Q3 LMNS Feedback	Q2 25/26 Provider Self-Assessment BRAG	Q2 25/26 Provider Update / Rationale for BRAG
Objective 1: Care is personalised	Is PCSP training included in the TNA?	LMNS note provider update	Blue	No change since Q1
	Are Personalised care audits being undertaken regularly?	LMNS note provider update	Green	Audit Plan uploaded
	Is the trust in a position to roll out MCoC	LMNS supporting Trust with the Building Blocks Action Plan, with a focus on an enhanced vulnerability model Trust to submit to the LMNS an operational delivery timeline for Q4	Amber	MCoC Action Plan uploaded. Quality Committee Paper recieves update each quarter
	Number of EMCoC teams operating in line with national guidance?	Sapphire Team in place at Ormskirk, rostered to cover intrapartum care only and hence currently does not meet national guidance - LMNS supporting Trust to meet national guidance Amethyst Team at Whiston in place, but also does not meet national guidance (covers antenatal and postnatal care) - LMNS supporting Trust to meet national guidance LMNS supporting Trust with the Building Blocks Action Plan, with a focus on the enhanced offer, following receipt of national funding	Amber	MCoC Action Plan uploaded. Quality Committee Paper recieves update each quarter
	Number of EMCoC teams planned to be rolled out in line with national guidance?	LMNS supporting Trust with the Building Blocks Action Plan, with a focus on the enhanced offer, following receipt of national funding	Amber	Update received from regional team
	Has the trust achieved UNICEF BFI accreditation?	Rre-accreditation dates to be submitted in Q4	Green	Ongoing audits undertaken and regular communication with UNICEF- plan remians in place for Q4 assessment- but no confirmed date at present.
Objective 2: Improve equity for mothers and babies	Does the trust provide access to interpreter services, which adhers to the Accessible Information Standard?	LMNS Assured in Q2	Blue	No change since Q1
	Is data collected and disaggregated based on population groups?	LMNS Assured in Q2	Blue	No change since Q1
Objective 3: Work with service users to improve care	Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services?	LMNS Assured	Blue	No change since Q1
	Date of last BR+	LMNS note provider update	Green	Engagement with BR+ and initial meeting held 3rd September 2025. Evidence uploaded
	Funded to BR+ establishment	LMNS note provider update	Blue	Biannual staffing reports uploaded (Jan-June 2025) presented at QC in September 2025 as part of the Maternity and Neonatal Update papers confirms both sites funded to BR+ recommended establishments
	Planned Date of Next BR+	Next BR+ will be commissioned at MWL following merger of STHK and S&0. Whiston site report received in October 2022- Plans to request next BR+ Q2/Q3 2025/26	Green	Engagement with BR+ and initial meeting held 3rd September 2025. Evidence uploaded
	Bi-Annual workforce plan for maternity and neonates including obstetrics in place?	LMNS note provider update	Green	Q1 Maternity and Neontal Paper for QC uploaded which
	Does the annual workforce plan include support for newly qualified staff and midwives who wish to return to practice?	No change from Q2 position	Green	No change since Q1

Objective 4: Grow our workforce	MW Vacancy Rate (please provide additional narrative to support data)	No change from Q2 position	Green	Cohort of NQM (Headcount 7) commenced in post WC 6th October- no actula midwifery vacancies. Awaiting quarterly PWR from regional team
	MW Leaver Rate (please provide additional narrative to support data)	No change from Q2 position	Green	Q4 and Q1 re uploaded. Do not appear in the evidence file- however if you download they are visible ?why - added as embedded objects. Awaiting Q2 summary from regional team
	MW Turnover Rate (please provide additional narrative to support data)	No change from Q2 position	Green	
	MW Sickness Rate (please provide additional narrative to support data)	No change from Q2 position	Green	
	Obstetric Consultant Vacancy Rate (please provide additional narrative to support data)	No change from Q2 position	Green	
	MSW Vacancy Rate (please provide additional narrative to support data)	No change from Q2 position	Green	
	Is there a retention midwife in post? (please provide additional narrative to support data)	LMNS note provider update	Blue	Midwives remain in post- no change. Lauren Griffiths and Ashley Latham.
Objective 5: Value and retain our workforce	Does the trust have a retention improvement action plan?	LMNS Assured	Blue	
	Is there a plan in place to reduce workforce inequalities?	LMNS Assured	Blue	No change since Q1
	Is the trust signed up to the North West Black, Asian, and Minority Ethnic Assembly Anti-racist Framework?	LMNS note provider update	Blue	No change since Q1
	Do the trust have a mechanism to Identify and address issues highlighted in student and trainee feedback surveys?	LMNS note provider update	Green	GMC Survey not yet received for 2025
	Does the trust offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time?	Preceptorship Programme in place. Further information requested in Q4 as per MPOP meeting	Blue	There is a preceptorship programme whcih facilitates supernumerary and development time to every newly registered midwife.
	Do the trust offer newly appointed Band 7 and 8 midwives support with a mentor?	Trust to submit SOP in Q4	Green	Offer of support is available to all newly appointed midwives via NW Coast Leadership academy- however it is not mandated that this offer is accepted
	Does the trust have a leadership succession plan which reflects the ethnic background of the wider workforce? .	LMNS note provider update	Green	People Plan Uploaded
Objective 6: Invest in skills	Does the trusts TNA aline with the core competency framework?	LMNS note provider update	Blue	No change since Q1
	Do junior and SAS obstetricians and neonatal medical staff meet RCOG and BAPM guidance for clinical and support suppervison?	LMNS note provider update	Green	No change since Q1
	Do temporary medical staff covering middle grade rota possess an RCOG certificate of eligibility for short-term locums?	LMNS note provider update	Green	Audits as per MIS Year 7
Objective 7: Develop a positive safety culture	Do maternity and neonatal leads have time within their job plan to access training and development, Including time to engage stakeholders, and MNVP leads?	LMNS note provider update	Blue	No change since Q1
	Have senior leaders attended national leadership programmes, including board maternity and neonatal safety champions?	LMNS assured	Blue	
	Does the trust board support the implementation of a focused plan to improve and sustain maternity and neonatal culture and regularly review progress?	LMNS assured	Blue	Qualitee Committee Paper Uploaded Sept 25
	Is there a clear and structured route for the escalation of clinical concerns? i.e. (Each Baby Counts: Learn and Support escalation toolkit).	LMNS assured	Blue	MWL SOP for Clinical escalation uploaded expires 02/10/28
	Is there a Freedom to Speak Up Guardian?	LMNS assured	Blue	No change since Q1
	Is there a FTSU training module for staff?	LMNS assured	Blue	
	Has the trust implemented PSIRF?	LMNS assured	Blue	

Objective 8: Learn and improve	Is there a formal structure to review and share learning? (with agreed timescales)	LMNS note provider update	Green	Ongoing- no change since Q1
	Has the organisation established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care?	ICB have endorsed the revised PSIRF plan for MWL which will be officially signed off by Trust Board in Q4 (Draft and Endorsement letter uploaded)		No change since Q1
	Has the organisation adopted a single point of contact process for families where ongoing dialogue is required with the trust?	LMNS note provider update	Green	No further updates regarding recruitment into role from corporate team
	Is the organisation sensitive to culture, ethnicity, and language when responding to incidents?	LMNS note provider update	Blue	No change sinjce Q1
	Is there a process of triangulation of outcomes data, staff, and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well?	LMNS assured	Green	Patient Experience, Pateint Safety and Quality Committee Reports uploaded
Objective 9: Support and oversight	Does the organisation share open and honest information on the safety, quality, and experience of their services?	LMNS assured	BLue	Exec Patient Experience Update
	Does the organisation regularly review the quality of maternity and neonatal services?	LMNS assured	Blue	QC Committee Paper Sept 2025 uploaded
	Have maternity safety champions been appointed, including NED?	LMNS assured	Blue	Acting NED appointed from 01/10/25
	Has the quadumverite been appointed?	LMNS assured	Blue	No change since Q1
	Are MNVPs involved in the development of the organisations complaints process?	LMNS note no change from Q2 position	Green	
	Are the MNVPs involved in the quality safety and surveillance group that monitors and acts on trends.	LMNS note no change from Q2 position	Green	
	Is FTSU data reported to board and acted upon?	LMNS assured	Blue	QC agenda June 2025
Objective 10: Standards to ensure best practice	Is the organisation on track to Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024?	LMNS assured	Blue	Quarterly submission to LMNS
	Is the organisation on track to adopt the national MEWS and NEWTT-2 tools by March 2025?	LMNS note provider update	Blue	Audit round up report including MEOWS
	Does the organisation regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services?	LMNS Assured	Blue	Quality Committee Septmber 2025 uploaded
	Has the organisation completed the national maternity self-assessment tool? .	LMNS Assured	Blue	No change
Objective 11: Data to inform learning	Does the organisation have a process for reviewing available data which draws out themes and trends and identifies and addresses areas of concern including consideration of the impact of inequalities?	LMNS note provider update	Blue	Quality Committee Septmber 2025 uploaded
	Does the organisation have a system that ensures high-quality submissions to the Maternity Services Data Set?	LMNS Assured	Blue	No change. Will submit as per MIS Year 7 SA2 demonstrating ongoing complinace
	Does the organisation have robust processes in place to ensure referrals to NHSR, MNSI, and the National Perinatal Epidemiology Unit?	LMNS note no change from Q2 position	Blue	No change since Q1
Objective 12: Make better use of digital technology in maternity and neonatal services	Does the organisation have a digital maternity strategy and digital roadmap?	LMNS Assured	Blue	No change since Q1
	Is the digital strategy and roadmap being implemented?	LMNS note provider update	Blue	Badgernet highlight report uploaded
	Does the organisation have an EPR system that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set?	LMNS Assured	Blue	Badgernet highlight report uploaded

BRAG Rating	
	Action is complete
	Action is on track
	Action mainly on track with some minor issues (mitigation in comments)
	Action not on track wit major issues (mitigation in comments)

Title of Meeting	**Trust Board**		**Date**	26 November 2025
Agenda Item	**TB25/090 (10.2)**			
Report Title	Maternity Incentive Scheme (MIS) Year 7 Update			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Sarah O'Brien, Chief Nursing Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

This report is intended to provide an update on the Maternity Services position in achieving compliance with the tensafety actions (SA) required from NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 7 in order to optimise the safety of women and babies in our care.

Executive Summary

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

To be eligible for payment under the scheme, the Maternity Service is required to be compliant with all ten safety actions and if assured, to submit a completed Board declaration form to NHS Resolution by 12 noon on 03 March 2026. The Trust CEO must ensure that the Accountable Officer (AO) for the Integrated Care System (ICB) is appraised of the MIS safety actions evidence and the declaration form and that they are both required to sign the declaration form to confirm they are both fully assured and in agreement with the compliance submission.

The report details current progress and evidence demonstrating assurance.

The Safety action standards that have evidence of full compliance are SA2 and SA 6. Safety actions 3,4,5,7,8,9 and 10 are currently compliant or on track for full compliance after the 30 November 2025.

SA3: The implementation of a transitional care service fully aligned to the British Association of Perinatal Medicine (BAPM) framework has been further delayed due to challenges in recruitment, retention, sickness and unavailability of staff. An updated transitional care (TC) action plan has been developed with revised clear timescales which requires submission to the Board and the Neonatal Operational Delivery Network (ODN) to establish compliance.

SA 4: Neonatal nursing workforce. The neonatal unit on the Whiston site has identified a deficit of 3.45 whole time equivalent (WTE) registered nurses based on activity levels following completion of the Q2 workforce calculator tool. An action plan has been developed which details the requirement to review the nursing establishment, undertake a business case and review the current neonatal cot configuration. The action plan will be presented to the Trust Board, ODN and Local Maternity and Neonatal System (LMNS) in November 2025 and will be monitored via the risk register to enable declaration of compliance.

The area of concern relates to:
SA1: Standard c) is currently non-compliant. To date there have been 12 cases that required a Perinatal Mortality Review Tool (PMRT) review started within two months of the death. The technical guidance states that as an absolute minimum all ten of the 'factual' questions in the PMRT tool must

be completed for the review to be regarded as started. Although all 12 were started within the required time period, a documentation error occurred resulting in one case only completing nine of the ten questions. The current compliance rate is below the 95% requirement at 91.7%. In order to obtain 95% compliance, the service would need 20 cases within the reporting period with 19 of 20 cases being compliant by the end of the reporting period of 30 November 2025.

LMNS were provided with evidence in relation to safety actions 3, 4, 5, 6, 7, 8 and 9 via quarterly engagement assurance meetings and the provision of evidence onto the Futures platform for review.

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

Financial Implications

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

Quality and/or Equality Impact

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

Recommendations

The Trust Board is asked to note the Maternity Incentive Scheme (MIS) Year 7 Update.

Strategic Objectives

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

Maternity Incentive Scheme Year 7 Update

1. Introduction

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

To be eligible to recover a 10% element of the Maternity Services contribution, we are required to submit a completed Board declaration form to NHS Resolution by 12 noon on 3 March 2026 and comply with the following conditions.

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

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

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

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

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

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

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

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

There are 10 safety actions with related technical guidance for the evidence, which the Maternity Service must achieve compliance with:

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

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

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

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

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

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

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

Safety action 8: Can you evidence the 3 elements of local training plans and 'in-house', one day multi professional training? Fetal monitoring training, multiprofessional maternity emergencies training and neonatal resuscitation training.

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

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?

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

2. Safety Action Compliance

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

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

The reporting timeframe is for the period 1 December 2024 to 30 November 2025 and the reportable criteria include late miscarriages/ late fetal losses (22+0 to 23+6 weeks gestation), stillbirths (from 24+0 weeks gestation) and neonatal deaths from 22 weeks (or 500g if gestation unknown) up to 28 days after birth. The required standards are:

a) Notification of all eligible perinatal deaths to MBRRACE-UK within 7 working days.
b) For at least 95% of all the deaths of babies eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.
c) 95% of deaths of babies who were born and died at the Trust from 01/12/24 onwards are required to have a PMRT multidisciplinary review started within 2 months of the death and a minimum of 75% of these reviews should be completed and published within 6 months.
For a minimum of 50% of deaths reviewed, an external member should be present at the MDT review panel meeting which should be documented within the PMRT.

d) Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board level safety champions and submitted to the Trust Executive Board on an ongoing basis from 1st December 2024.

The reporting period for Safety action 1 is 1st December 2024 to 30th November 2025.
The information within this update paper includes the latest data for the period from 01/12/24 to 29/10/25 with the following findings:

a) Notification of all eligible perinatal deaths to MBRRACE-UK within 7 working days.
There have been 16 death that have been required to be notified to MBRRACE. All 16 death have been notified within 0-4 days of the death demonstrating 100% compliance.

Compliant to date

b) For at least 95% of all the deaths of babies eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.
Of the 16 deaths, twelve cases were eligible for a PMRT review. 3 cases were excluded due to being terminations of pregnancy and parents' views are not required in those cases and 1 case were a baby born was born alive at 21+6 weeks gestation but sadly subsequently died and did not meet the criteria for PMRT review.

Of the remaining 12 cases, they all have met the standards and have sought parents' views therefore demonstrating 100% compliance to this criterion.

Compliant to date

c) i: 95% of deaths of babies who were born and died at the Trust from 01/12/24 onwards are required to have a PMRT multidisciplinary review started within 2 months of the death
Of the12 cases that required a PMRT review, all 12 cases had a review started within 2 months of the death. The technical guidance states that in order to comply with starting a review, the death is required to be notified to MBRRACE, the PMRT tool must be used to complete the first review session (Which may be one of several sessions) and as an absolute minimum all 10 of the 'factual' questions in the PMRT tool must be completed for the review to be regarded as started.
11 of the 12 cases have met this criterion however 1 case was started using the tool within the required time frame with 9/10 questions answered and therefore for an MIS position this case is classed as non-compliant as the current compliance is only 91.7%.

NHSR were contacted for advice and responded on 24/10/25. They have advised that The Maternity Incentive Scheme (MIS) external verification process for PMRT referrals is conducted by MBRRACE, and they are the final arbiter of any decisions made. NHSR and MBRRACE are not looking to penalise a Trust for isolated incidents in reporting, however these would be considered alongside any previous breaches within the MIS reporting period that may be identified, and the complete picture will be reviewed by the team at the end of the MIS period.

MBRRACE will take it into consideration if the Trust has acknowledged any potential issue/s and has put in place steps to rectify them. The NHSR team will notify MBRACCE on our behalf will and they will review the MWL position at the end of the MIS reporting period.
The advice is that if MWL do not meet the 95% criteria at the end of the reporting period is to declare non-compliance with SA1 with a clear narrative in our Board report reflecting the external verification process as described and complete the 'action plan' section in the MIS Board notification form.
In order to obtain 95% compliance, the service would need 20 cases within the reporting period with 19/20 being compliant.

Currently non compliant

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

Of the 12 cases, 6 of these cases would be eligible for completion and publication before the end of the reporting period for MIS Year 7 of the 30th November 2025.

4 /12 have met the required standard as the reports have been completed and published within the 6-month timeframe.
The additional 2 cases are in the final completion phase and will be completed by the deadline of the 30th November 2025.
Of the cases not within the MIS reporting period, 2 are anticipated to be completed an published ahead of schedule and the remaining 4 cases are in various stages of the PMRT review and report writing.

Currently compliant

iii: For a minimum of 50% of deaths reviewed, an external member should be present at the MDT review panel meeting which should be documented within the PMRT.
The 6 cases within the MIS reporting period have undergone a PMRT review and all have had an external panel member present at the review meetings demonstrating 100% compliance
2 cases outside the current MIS timeframe have also had PMRT meetings with an external panel member present with the remaining 4 reviews not yet having a panel date set.

Currently compliant

d) Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board level safety champions and submitted to the Trust Executive Board on an ongoing basis from 1st December 2024.

A quarterly maternity and neonatal update paper is presented to Quality Committee which details all deaths, including themes and lessons learnt. All required quarterly reports have been completed and presented as required in February, May, September and November 25. The Quality committee receives a monthly IPR alongside data from the PQSM as a standing agenda item detailing perinatal mortality.

Currently compliant

Due to the documentation error in element ci) where one factual accuracy entry was omitted the overall compliance for safety action 1 is currently non-compliant

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

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

- The July 25 data must contain valid birthweight information for at least 80% of babies born in the month.
- The July 2025 data is required to contain valid ethnic category (Mother) for at least 90% of women booked in month. Not stated, missing and not known are not included as valid records for this assessment and are expected to be used only in exceptional circumstances.

The MSDS score card from NHSE was published on 23rd October 2025 and confirmed that MWL had achieved 100% compliance for the required month of July 2025 to both of the required

standards and therefore the MWL maternity service has fully met the required compliance for MIS Year 7.

Compliance: Achieved

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

The required standards for SA3 are:

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

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

The Whiston site currently provides elements of the BAPM TC framework with associated pathways in place. An action plan was developed and signed off by the Trust with clear timescales and evidence of progress towards full implementation being monitored following approved funding to staff a TC service compliant with BAPM.

The additional funding included additional nurse and maternity support worker staffing. Recruitment has proved challenging and has undergone numerous recruitment drives with several staff declining posts immediately prior to commencement and staff leaving after starting requiring further advertisement. Employed staff are in various stages of recruitment, orientation and training and alongside current vacancies, sickness and absence has resulted in deferments of implementation dates.
A revised September implementation date was scheduled however continued vacancies, increased sickness and unavailability of neonatal nursing staff has deferred this date further with a revised commencement date of end March 2026. Progress updates have regularly been shared with the Trust Quality committee via the quarterly maternity and neonatal reports with the previous update being on 19/09/25, discussed at the Trust safety champions meetings, Executive monthly Divisional performance reviews and during the quarterly LMNS meetings.

The Transional care action plan has been updated with revised timescales and is included in the maternity and Neonatal November quarterly update which was presented to Quality committee on 18th November 2025.

The Trust is compliant with TC local admission criteria based on BAPM, demonstrating at least 1 element of HRG XA04 activity which includes low birth weight babies, babies who are on a stable reducing programme of opiate withdrawal, tube feeding, intravenous antibiotics and phototherapy.

b) Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on the initiatives must be shared with the safety champions and LMNS.

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

The Whiston site registered their project on the 6th August 2024 which related to the implementation of Newborn Early Warning Track and Trigger framework (NEWTT 2) that is used in the postnatal care environment to support monitoring of baby. Elements including promotion of skin to skin and the completion of neonatal observations were identified to ensure timely interventions were undertaken.
The Ormskirk site registered their project on 29th August 2024 which relates to thermoregulation of the newborn.

Both quality improvement initiatives have continued from MIS Year 6 and significant progress and improvement has been demonstrated 6 months into Year 7 and will be demonstrated at the end of the MIS reporting period. Progress updates have been shared with the LMNS and Trust safety champions in September 2025. Further updates are scheduled for the November Trust safety champions meeting alongside a presentation update with the LMNS, scheduled for both sites on 24th and 25th November.

The maternity service is on schedule to meet the required standard for safety action 3.

Currently Compliant:

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

a) Obstetric Workforce:

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

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

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

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

2. Trusts should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Board, Trust board safety champions and the LMNS Board.

   A six-month audit is required for the period after February 2025 to 30 November 2025 for the engagement of long-term locums in accordance with RCOG guidance. The audit period covered 1st February- 31st August 2025 and during this period there were no long-term locums employed.

The audits were scheduled for the trust safety champions meeting on 07/11/25 and are included in the quarterly maternity and neonatal update scheduled presented at Quality Committee on 18th November and subsequently in order to provide evidence of compliance.

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

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

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

4. Trusts need to ensure they are compliant of consultant with Consultant attendance in person for clinical situations as listed in RCOG workforce document for a minimum of 80% of applicable situations: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' in their service.

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

   On the Whiston site, the monthly audits are presented and monitored at Maternity Forum and the Obstetrics and Gynaecology Clinical Governance and Quality meeting. On the Ormskirk site the audits are collated quarterly due to the smaller number of clinical incidents and presented via the Governance meetings. A combined MWL aggregated audit has been presented to Trust Safety Champions meeting on 7th November which included as appendices the individual audits The evidence of compliance is included in the maternity and Neonatal update report for the Quality committee to review and additionally submitted to the LMNS via the reporting portal for review at the quarterly MIS meetings.

   For the 6-month reporting period, April – September 2025 there were 48 clinical situations across both maternity sites where a consultant must attend. The consultant was in attendance for 42 (94%) cases. There were 3 cases where a consultant was not in attendance which were: a woman who had a total blood loss of PPH 2020mls. The Consultant was notified when the blood loss reached 1650mls but there was no further ongoing bleeding and therefore did not attend. The final blood loss was confirmed as being over 2000mls, the second incident to a woman who had a CS with a BMI of 50 and a woman who sustained a fourth-degree tear.

   All cases have been reviewed and discussions undertaken or to be undertaken with relevant staff in relation to escalation and documentation. The fourth-degree incident additional underwent a PSIR review.

   There were 302 cases within this reporting period for situations in which the Consultant must attend unless the most senior doctor present has documented evidence as being signed off as competent. There was 100% compliance to this criterion.

   Compliance: Achieved

b) Anaesthetic Workforce:

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

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

Compliance: Achieved

c) Neonatal Medical Workforce:

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

For the both the Whiston and Ormskirk sites the neonatal medical staffing is compliant to BAPM standards for Tier 1, 2 and 3 as agreed by the ODN during their annual visit on 1st May 2025 and remains currently compliant to date and required to be formally recorded in the Trust Board minutes. **Currently Compliant:**

d) Neonatal Nursing Workforce:

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

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

The neonatal unit on the Whiston site completed the Q2 workforce calculator tool which was submitted to the ODN in October 2025. The tool identified that there is now a deficit of 3.45WTE registered nurses based on activity levels. The tool includes a separate tab for transitional care staffing although transitional care on the ward to full BAPM standards has not been commenced as detailed in SA3. An action plan has been developed which is included as an appendix in the Maternity and Neonatal Update and includes the requirement to review the nursing establishment, undertake a business case and review the neonatal cot configuration. The action plan presented to Trust Board via the Q2 maternity and Neonatal update paper and submitted to the ODN and LMNS in November 2025. The plan will be monitored via the risk register and included in the quarterly maternity and neonatal update papers to Quality committee.

Currently Compliant

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

A Birthrate Plus maternity workforce assessment has been undertaken for both sites in 2022 and within the last three years that provided an evidence-based process to calculate midwifery staffing establishment in accordance with MIS SA5 standard a) requirements.
Discussions and meetings have commenced with Birthrate + to undertake a full maternity workforce assessment which will commence either towards the end of Q3 or beginning of Q1 2025/26.

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

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

Alongside the maternity and neonatal quarterly update papers, biannual staffing reports are produced. The January – June 2025 Biannual staffing reports were presented to Quality Committee in September 25 and included in the Q2 maternity and neonatal update papers for information. The staffing reports demonstrate evidence of the breakdown of Birthrate Plus (BR+) and that the staffing budget reflects the establishment as against BR+ based on the current model of care, the midwife to birth ratio, maternity red flags and the percentage of specialist midwives / management employed which accounts for 9% of the establishment on both sites who are not included in the clinical numbers. The service is currently reviewing midwives in fixed term externally funded posts to ensure continuation of these services in the future and those recommended by Ockenden which is likely to require a business case in the future.

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

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

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

The six elements for SBL are:

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction

- Element 3: Raising Awareness of Reduced Fetal Movements
- Element 4: Effective Fetal Monitoring in Labour
- Element 5: Reducing Preterm Birth
- Element 6: Management of pre-existing diabetes

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

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

The Division have worked closely with the LMNS and have, to date, held nine quality improvement discussions to date with scrutiny of progress monitored using the national SBLCBV3 Implementation Tool through the NHS Future Portal. In the year 7 reporting period of 2nd April – 30th November 2025, there have been two LMNS review meetings and therefore meeting the minimum requirements of at least two in the MIS reporting period of 2nd April to 30th November 2025.

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

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

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

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

Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction
Compliance has decreased. Services are transitioning from GROW 1.5 (paper-based) to GROW 2.0 (electronic) for monitoring fetal growth. An action plan is in place for full implementation.

The service is also reviewing capacity to introduce a reduced scan interval (from 3–4 weeks to 3 weeks) for at-risk women of a small for gestational age or growth restricted baby, in line with the Regional Guideline. If the current 3–4-week interval is retained, a Trust-specific guideline will need to be drafted and receive LMNS approval.

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

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

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

No evidence was uploaded from the Ormskirk site relating to the rates of intraventricular haemorrhage in neonates from the NNU's NNAP data, this should be available for the next evidence submission, and this therefore affected the overall compliance rates.

For the Whiston site, the issue related to documentation and confirming to the LMNS that there were no cases that occurred in Q4 and therefore no audit was required.

Element 6: Management of Pre-existing Diabetes
Five of six recommendations are fully compliant.

The one recommendation not fully met is a new recommendation addressing the risk of fetal death from diabetic ketoacidosis (DKA). It requires that all pregnant women presenting with DKA in

secondary care receive ongoing multidisciplinary consultant input and care in accordance with the jointly agreed Trust policy. The services are currently aligning the previously separate DKA policies with the Trust-wide diabetes policy.

The next evidence submissions are due to be uploaded to the NHS Futures platform with a further improvement discussion with the LMNS utilising the SBL implementation tool as evidence scheduled for 16th December.

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

The LMNS remain satisfied with the ongoing progress of MWL in implementing the Saving Babies' Lives Care Bundle, with monitored action plans focused predominantly on audits and documentation and noting the changes introduced increasing the compliance target.

Compliance: Achieved

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

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

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

Infrastructure.

The service currently has 2 MNVP leads with funding via the ICB. The leads have job descriptions, person specifications, service agreements which includes confirmation of availability of funding for, out of pocket expenses, childcare if required, training and communication etc. The MNVP leads provide an independent view for to the maternity service but work alongside the service leads.

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

The maternity service is currently awaiting formal confirmation from the MNVP leads as evidence of receipt of funding

Strategic influence and decision making

The minimum evidential requirements identify that the terms of reference (TOR) for Trust safety and governance meetings must showing the MNVP lead as a member. The service can evidence that the following meetings terms of reference are compliant, Trust Safety champion meetings, Maternity quality and governance and Intrapartum forum.

Currently the MWL MNVP's do not have capacity, the experience, and/or training to support consistent and meaningful participation in PMRT panels and key governance meetings. As such, the service is currently unable to guarantee MNVP representation as a quorate member at these meetings, which is a recognised requirement within the broader Maternity Incentive Scheme (MIS) framework. In line with NHSE guidance, where an MNVP service does not meet all elements, the Trust is still able to declare compliance with Safety Action 7 following escalation to Trust board. This issue was presented and discussed within the maternity and neonatal quarterly update presented to Quality Committee on 16th September for escalation to Board. The issue of MNVP attendance at PMRT meetings has been raised by several organisations regionally and nationally and is currently being considered by NHSR. The concern identified has related to the MNVP exposure to graphic medical illustration details and content within pathology findings which can be upsetting. MBRRACE have released online training for Trusts and MNVP to access.
Discussions have been undertaken and continue with our current MNVP leads in order to reprioritise governance meetings and engagement work based on their views and will include additional hours following commencement of our newly appointed MNVP lead. Attendance at the PMRT meetings is still undecided to date as a decision from all our MNVP is not known. The service will support any of the MNVP leads to access MBRRACE training and develop restorative and reflective discussions to ensure support due to the sensitive nature of cases discussed.

The Maternity service is therefore escalating the current non-attendance at key governance meetings especially PMRT and further updates and actions will be presented.

Engagement and listening to families

Engagement and listening to families require evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.
Actions that have been undertaken to date to support engagement and listening to families include:

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

Currently Compliant:

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

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

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

The maternity service is on track to meet the required standard for safety action 8 with all required staff groups attendance for each training element >90% by 30th November with staff rostered to attend scheduled dates in November.

Verified Compliance for the staff groups as of 31st October is detailed below.

Ormskirk Site:

CNST Y7 Training Period 1st December 2024- 31st October 2025		
Fetal Surveillance	Consultant Obstetrician	100.0%
	Other Obstetric Doctors	92.3%
	Midwives	92.4%
PROMPT	Consultant Obstetrician	92.3%
	Other Obstetric Doctors	68.4%
	Midwives	84.0%
	MSW	81.5%
	Consultant Anaesthetist	66.7%
	Other Anaesthetic Doctors	68.8%
NLS	Midwives	90.8%
	Neonatal Consultants	80.0%
	Other Neonatal Doctors	87.1%
	Neonatal Nurses	84.0%
	ANNP	100.0%

Whiston Site:

CNST Y7 Training Period 1st December 2024- 31st October 2025		
Fetal Surveillance	Consultant Obstetrician	85.0%
	Other Obstetric Doctors	95.0%
	Midwives	95.1%
PROMPT	Consultant Obstetrician	75.0%
	Other Obstetric Doctors	82.8%
	Midwives	90.5%
	MSW	92.9%
	Consultant Anaesthetist	57.1%
	Other Anaesthetic Doctors	82.8%
NLS	Midwives	90.5%
	Neonatal Consultants	90.9%
	Other Neonatal Doctors	96.5%
	Neonatal Nurses	89.2%
	ANNP	100%

Whilst not formally monitored as part of MIS, throughout the scheme year other staff groups who are part of the multidisciplinary team providing maternity care at MWL including theatre staff, anaesthetists who do not contribute to the obstetric rotas, paramedics and student midwives have attended the training days for their own personal development. This is considered to be good practice and demonstrates recognition that multi-professional training contributes to safer maternity care.

Dates for training continue in November 2025 with staff rostered to attend which will achieve the minimum 90% attendance.

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

Compliance: On track

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

A national recommendation from the Ockenden Report was the proposed introduction of a Perinatal Quality Surveillance Model (PQSM) and the required standard is that all requirements of the PQSM must be fully embedded with evidence of the Trust working towards the revised Perinatal Quality Oversight Model (PQOM) that was published in 2025.
There is an expectation that discussions regarding safety intelligence takes place at Trust Board (Or an appropriate subcommittee with delegated responsibility) which include ongoing monitoring of services and trends with evidence of reporting and escalation to the LMNS/ ODN/ ICB/ Local and regional learning systems.

All Trusts must have Maternity and Neonatal Board Safety Champions who are actively supporting the perinatal leadership team in their work to better understand and craft local cultures.

The Trust has an appointed Non-Executive Director who attends the Maternity Safety Champions meetings, undertakes safety champion walkabouts across the maternity and neonatal services across MWL and attends Quality Committee and Trust Board and who works with the Board safety champions and the Perinatal leadership team. Details of trends, safety issues and any safety escalations are discussed, logged, actioned and presented at the Safety Champions Meeting. Feedback to staff is completed through a wide variety of communication channels.
The Board safety champion additionally has an open invitation to the weekly Triumvirate meeting. A log of attendance and actions is maintained, and compliance has been achieved of attendance of a minimum of three in MIS reporting period which has vastly been exceeded.

The Perinatal Quality Surveillance Model (PQSM) template developed by NHS England is utilised and a combined PQSM for MWL was developed with the data additionally included in the monthly IPR. Monthly IPR and patient safety incidents are reported to Quality committee and Board alongside being included within the local and regional maternity clinical dashboard and maternity and neonatal quarterly update papers. The PQSM is additionally included monthly with the Quality Committee and Trust safety champion meeting agendas. All serious incidents are reportable and escalated to MNSI. All completed reports are submitted to the LMNS/ODN and presented at the single serious incident Cheshire and Merseyside patient safety meetings.
Quarterly Maternity and Neonatal update reports are submitted to Quality Committee and presented by the Divisional Director of Midwifery or member of the perinatal leadership team providing evidence of how information is shared at Trust level to ensure that early action and support for areas of concern are highlighted.
The Maternity Claims Scorecard is discussed at the Safety Champions Meeting, presented to patient safety council and included and triangulated alongside incident and complaint data within the maternity and neonatal quarterly update and is used to agree targeted interventions aimed at improving patient safety.

There is representation from the maternity and neonatal service who attend shared meetings with the LMNS/ICB where Trust and system level intelligence are presented and discussed. Examples of this include the Maternity Safety Oversight Group (MNSG) , Quarterly engagement meetings reviewing Saving Babies Lives v3, MIS compliance, Clinical Quality Safety Surveillance Group

(CQSG), Maternity Performance Oversight Panel (MPOP), ODN and LMNS assurance visits demonstrating how Trust-level intelligence is escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

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

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

- Monthly unit meetings to enable feedback and provide the opportunity for staff to raise issues, concerns, suggestions for improvement etc.
- HR availability and drop in sessions
- Learning and development accessibility and sessions within the clinical area for staff
- Promotion of freedom to speak up and action plans and feedback if issues raised
- Monthly Safety champions walkabout
- Triumvirate 'Talk to us Tuesdays and Thursdays'
- Weekly teams' and executive meeting as required following temporary pathway changes to enable communication to staff and opportunity to raise any questions and respond.

The Maternity and Neonatal Service participated in the Perinatal Culture and Leadership programme. As part of this programme a SCORE Culture survey was undertaken and an improvement plan has been developed based on the diagnostic findings and is included as Appendix 1 for sharing with the Trust Board.

Currently compliant

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

The standards for this safety action include the requirement to report all qualifying cases to MNSI and to report all qualifying Early Notification (EN) cases to NHSR EN scheme for the reporting period 1st December 2024 until 30 November 2025.
From the 1st December 2024 until 4th November 2025, there were 6 cases that were eligible for reporting to MNSI which were all completed.

3 of the cases that were reported to MNSI did not qualify for reporting to the NHSR EN scheme. One case was a neonatal death, and 2 cases were babies that required cooling, but the babies clinical and MRI scans were reported as normal. One of these cases is undergoing an MNSI investigation at the parents request however the technical guidance stipulates that if the clinical and MRI scan is normal reporting is not required even if an investigation has been accepted by MNSI.

A referral to NHSR EN scheme has not been submitted for a case that occurred in October 2025 due to a pending decision form MNSI for acceptance of the case. If a decision to accept is made the appropriate referral will be undertaken.

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

- One case was reported but following the final investigation report the referral was declined by NHSR.

- One case was reported and initially accepted by NHSR. The clinical outcomes confirmed that the baby did not have HIE but had experienced a perinatal stroke and NHSR immediately closed the case following this information.

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

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

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

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

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

Currently Compliant

3. Conclusion

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

Evidence in relation to safety actions 3-9 have been submitted to the LMNS/ ICB either through ongoing improvement discussions or via evidence uploaded to the futures platform.

The evidence in relation to all 10 safety actions demonstrates the current compliance status to MIS year 7 as many cannot be assessed as fully compliant until either the end of the reporting framework.

Safety Action	Safety Action Title	Current compliance	Anticipated compliance
1	Use of the National Perinatal Mortality Review Tool to review perinatal deaths that occurred from 1st December 2024 to 30th November 2025 to the required standard?	Non-compliant	Unknown

2	Submission of data to the Maternity Services Data Set (MSDS) to the required standard?	Compliant	Compliant
3	Demonstration of transitional care services in place and undertaking quality improvements to minimise separation of parents and their babies	Currently Compliant	Compliant
4	Demonstrate an effective system of clinical workforce planning for Obstetric, Anaesthetic and neonatal medical workforce and the neonatal nursing workforce.	Currently compliant	Compliant
5	Demonstrate an effective system of midwifery workforce planning to the required standard.	Currently Compliant	Compliant
6	Demonstrate that the service is on track to achieve compliance with all elements of the SBLCB V3	Compliant	Compliant
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Currently Compliant	Compliant
8	Evidence of compliance to the 3 elements of local training plans and 'in-house', one day multi professional training and neonatal resuscitation training.	On track	Compliant
9	Demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues	Currently Compliant	Compliant
10	Reporting of 100% of qualifying cases to MNSI and to NHSR Early Notification Scheme from 1 December 2024 to 30 November 2025	Currently Compliant	Compliant

4. Next Steps / Priorities

- Continue to review and collate Year 7 evidence until the end of the reporting timeframe and collate and prepare a final position report
- Monitoring of SA 4, Neonatal staffing with associated business case following establishment review.
- The Maternity Service will continue to provide evidence via the Futures platform to the LMNS alongside quarterly quality improvement discussions regarding implementation of SBLCB v3.0 to meet full implementation and monitoring of ongoing audits.
- Quality Initiative Presentation to the LMNS scheduled for 24th and 25th November 2025
- MIS supporting paper and presentation to be presented to Trust Quality committee by the Divisional Director of Midwifery and the Divisional Medical Director on 20th January 2026
- MIS supporting paper and presentation to be presented to Trust Board by the Divisional Director of Midwifery and the Divisional Medical Director on 28th January 2025
- The Trust declaration form to be signed by the Trust CEO and by the AO of the ICB and submitted to NHSR by 12 noon on 3rd March 2026 once Board confirmation of status is confirmed.

5. Recommendations

The Committee are asked to note and approve the contents of the report.

Appendix 1: Maternity and Neonatal Perinatal Culture leadership plan

Theme	Issue	Action	Owner	Date commenced/ comments
Leadership	Feeling valued and understood with visibility and communication	• Establish regular listening events with HR support • Establish Talk to us Tuesdays and Thursdays • Monthly unit meeting in Maternity • Monthly Ormskirk engagement sessions • Engagement with O+D to support leadership team with perinatal culture leadership plan	HR Business Partner/ Leadership Team DDOM/ matrons DDOM Leadership team/ Head of O+D	May 2025 May 2025 Established on Whiston site and due to commence on November 25 in Ormskirk Established April 2025
	Positive feedback and appreciation.	• Star of the month already established in place in maternity and extend across the Division • Nominations for nursing and midwifery day • Use of in phase for acknowledgement • Feedback Fridays	Matrons/ DM All Governance team Leadership team	August 2025 May 2025 April 2025 Established
Team Working	Fairness in Rota management. Ensure sufficient staff on shift	• Trial of unlimited requests for rosters • Rolling recruitment programme	Ward Managers Matrons	April 2025 Ongoing

		• Biannual maternity staffing papers to Trust Board • Quarterly maternity and neonatal staffing updates to QC including compliance with BAPM and BR+ • Establishment reviews	DOM DOM DOM/ DDOM/ HR/ Finance/ matrons	On going Ongoing Jan 25 and Nov 25
	Perceptions around workload. Time for delivery of care as staff felt this was not always available.	• Increased review of skill mix on rotas. • Roster challenge and WUG meetings • Daily Huddles with Maternity team including community midwifery	Matron/managers DoM/ DDOM Managers/ matrons	April 2025 June 2025 Ongoing
	Work life balance. The majority of staff described the impact of work and burnout.	• Use of unlimited requests through roster • Effective roster management • Monitoring staff breaks • Flexible working requests. • HR drop-in sessions in clinical areas/ workshops	Manager/ Matrons Manager/ Matrons Managers/ bleep holders Matrons/ DDOM HRBP	April 2025 Ongoing Ongoing As requested, March 25
	Long standing team normal behaviours. Several leaders described difficulties in implementing standards or behaviours	• Regular Quality Walk abouts • Safety huddles • Ability and promotion of FTSU • Walkabout by Trust safety champions • Challenging of any unacceptable behaviours. HR/ LD support as required. This has included support, investigations etc	Corporate team/ leadership team All All TSC Leadership team/HRBP	January 2025 Ongoing Ongoing Annual walk about plan ongoing Ongoing

		• Quality bus – raising awareness of professional expectations, behaviours and values, expected communication and language etc.	Governance team	January 2025
Learning	More opportunities for training. Some people would value time out to train and ensure skills are up to date.	• Training programme for FIN and QIS in place • ANNP development programme • Learning opportunities discussed during appraisals • Secondment opportunities in specialist roles • Developmental roles • Networking across sites	Neonatal/ Paediatric Matrons Neonatal/ Paediatric Matrons All DOM/ DDOM DOM/ DDOM All	April 2025 – 2026 December 2024 In place Ongoing Ongoing Ongoing
Collaboration	Improve MDT working. The effectiveness of team working would be improved through people being kind and showing mutual respect, regardless of grade.	• MDT in place • Increase collaboration across sites and throughout newly formed Division	Leadership team/matrons	April 2025

Title of Meeting	**Trust Board**		**Date**	26 November 2025
Agenda Item	**TB25/091**			
Report Title	Digital Strategy Update			
Executive Lead	Malcolm Gandy, Director of Informatics			
Presenting Officer	Malcolm Gandy, Director of Informatics			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

The Trust's Digital Strategy, approved in March 2024, followed the merger of the legacy St Helens and Knowsley and Southport and Ormskirk Trusts. At the time, the organisations were on completely separate infrastructure and working across sites was very difficult. The strategy needed to have a strong focus on technical consolidation and solution convergence to enable staff to be able to work across all sites and work as single teams. With capital investment much of the digital foundation has now been completed and from an end user they can work across any of the Trust sites.

Over the last year the Trust has delivered good progress across digital systems, infrastructure, interoperability and digital maturity, establishing the foundations for the next phase of transformation.

One significant development in 2025 has been the agreement to run a collaborative Electronic Patient Record (EPR) re-procurement with Warrington and Halton Teaching Hospitals NHS FT (WHH), aiming for a single, shared-instance EPR that delivers clinical standardisation, operational efficiency, and improved integrated care pathways. Work is underway to design the revised procurement, Pre-Market Engagement (PME) with the launch expected in early 2026.

Whilst there is still some work to do on the digital foundation, mainly with telephony, the strong technical foundation in place has enabled a shift in focus to clinical applications and innovation using Artificial Intelligence (AI) and Robotic Process Automation (RPA) to enable the transformation of our clinical services.

Alongside this, the Trust continues to focus on a programme of EPR readiness and clinical optimisation, including Trust-wide deployment of CareFlow Narrative, documentation standardisation work, Electronic Prescribing and Medicines Administration (EPMA) proof-of-concept testing, automation of Take Home Medication (TTO) workflows, maternity system development and early preparations for Outpatient clinic redesign.

The Trust's technical and cyber infrastructure has significantly matured, with the successful completion of the data centre and server replacement programme, migration to a single firewall, completion of email consolidation, improved device performance, and continued progress toward a single domain network. This foundation improves system reliability, performance, mobility and cyber resilience.

MWL also continues to play an important leadership role within the Integrated Care System (ICS), particularly in the pathology digital agenda and the Cheshire & Merseyside (C&M) Laboratory

Information Management System (LIMS) programme and remains an active partner across system-wide convergence initiatives.

This year has also seen a major step forward in the Trust's AI, automation and digital innovation capability, marked by the establishment of the AI & Automation Steering Group, early adoption of Microsoft Copilot, maturation of RPA capability, and plans to launch an Ambient Voice Technology pilot in late 2025/early 2026.

Looking ahead to 2026, the Trust's priorities include:

- Launch and execution of the collaborative EPR procurement
- Continued EPR readiness including workflow standardisation and data migration preparation
- Further delivery of the Digital Levelling-Up Programme
- Progression of telephony and infrastructure convergence
- Development of a refreshed Digital Strategy aligned to the Trust's Five-Year Plan, ICS and National digital ambitions
- Expansion of AI and automation to support clinical and operational efficiency

The progress achieved reflects the commitment of clinical, operational and digital teams and provides a high level of confidence ahead of the next major phase of digital change.

Financial Implications
Not applicable

Quality and/or Equality Impact
Not applicable

Recommendations
The Trust Board is asked to note the Digital Strategy update.

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

Introduction

Over the last year the Trust has delivered a good deal of progress across digital systems, infrastructure, interoperability and digital maturity, establishing the foundations for the next phase of transformation.

One most significant development in 2025 has been the agreement to run a collaborative Electronic Patient Record (EPR) re-procurement with Warrington and Halton Teaching Hospitals NHS FT, aiming for a single, shared-instance EPR that delivers clinical standardisation, operational efficiency, and improved integrated care pathways. Work is underway to design the revised procurement, PME (Pre-Market Engagement) with the launch expected in early 2026.

Alongside this, current EPR optimisation and future readiness activities are progressing:

- Careflow Narrative (Clinical Noting) is now live across the Trust
- Documentation standardisation and CareFlow Connect roll-out are progressing
- EPMA proof-of-concept is progressing Trust-wide
- TTO automation pilot begins November/December 2025
- Outpatient clinic rebuild planning is advancing
- BadgerNet maternity solution build is underway

Infrastructure resilience has strengthened further with:

- Delivery of the datacentre and server upgrade programme
- Consolidation of the Trust's cyber posture through a single firewall
- Completion of email migration to merseywestlancs.nhs.uk
- Continued device lifecycle replacement
- Progress towards a single domain network

Regionally, MWL continues to lead the Cheshire & Merseyside LIMS programme and remains an active partner across ICS digital convergence initiatives.

AI, automation and digital innovation capacity has increased with the formal establishment of the AI & Automation Steering Group, early Copilot adoption, robotics consolidation and an Ambient Voice Technology (AVT) pilot planned for December 2025/January 2026.

The work completed during 2025 positions the Trust to continue to progress its EPR mobilisation, digital maturity uplift and integrated care improvements during 2026.

Infrastructure Convergence

A significant amount of work has taken place to implement a whole new back-end server and storage infrastructure and then migrate all of the legacy systems on to this. This means the solutions are on supported, secure, modern infrastructure and in some cases, opening up applications has significantly improved. In general, staff will now be experiencing the following:

- faster logins
- faster usage of the clinical applications
- can work across any site and access all applications from any location.
- able to print at any site.
- can communicate quicker and easier with colleagues.

This means staff are more mobile and can now really focus on standardising their clinical processes and review the use of clinical applications to support the transformation of clinical services.

Work will continue throughout 2026-2027 to merge the telephony systems, aligning these with our patient portals. This will improve contact into the Trust from patients / families, being complimented by some new AI technology.

Levelling Up Programme

The patient engagement portal (PEP - Netcall) has gone live this year at the S&O sites, and the waiting list validation module has also gone live at STHK. The PEP integrates with the National Patient Portal which enables patients to view hospital correspondence, and in future will allow patients to manage their appointments remotely without direct communication with the trust.

The legacy letter production system, Transform, at STHK has been upgraded which has removed significant information security vulnerabilities. The programme to rebuild the STHK clinics and enable the implementation of the PEP and associated benefits (i.e. reduce postal costs) is under review and progressing.

Work is ongoing to standardise digital clinical documentation across the trust, which is now enabled with the implementation of narrative at the S&O sites, and also the continued roll out of the CareFlow Connect system. The Narrative system has now been fully moved to business-as-usual support, and a programme is being developed to manage the demand for the standardisation and development of digital forms within the EPR.

Work in ongoing to build and implement the Badgernet maternity system. Availability of the clinical teams have been impacted by the service reconfiguration within maternity, and this has been adversely the programme progress. The team are now working to understand how the deployment can be safely achieved within the timescales that were outlined at the beginning of the year.

The deployment of EPMA at the S&O sites is ongoing, the proof-of-concept testing is now underway following some initial integration challenges. It is expected that the testing will conclude by the end of November, following this a decision will be made the EPMA programme team regarding the deployment and go live methodology.

Operational Transformation using AI/RPA

Our clinical services are stretched and are continually being asked to deliver more with less. A key enabler to improving productivity is to exploit the use of digital solutions that Artificial Intelligence (AI) and Automation solutions can give us.

This year, the Trust launched an AI and Automation Steering Group to enable us to manage the introduction of AI in a safe, secure and ethical way. Current usage of AI within the Trust includes:

- Brainomix – Diagnostic Tool for stroke patients
- Annalise, medical imaging decision tool for chest x-rays, pilot began September 2025
- iRefer – supportive referral tool for diagnostic services – getting the right referral first time
- Skin Analytics – Diagnostic AI tool
- D.A.V.E. chatbot used for IT service Management
- Copilot Web for 100 staff to improve administrative work such as document writing.
- Netcall Patient Hub DNA AI predictor – not implemented yet.
- C2AI – surgical waiting list optimisation solution
- Homecare AI - Azure AI model trained on local prescription formats. Power automate flows decodes PDF scans and uploads to the Patients EDMS record, replacing manual process.
- Tideway (Theatre Scheduling) – Proof of concept/pilot due to go live in January 2026 for theatre scheduling optimisation.

To give an example of the usage of AI within the Digital Service the use of D.A.V.E. is increasing:

Reduction in manual logging and increased, faster approvals via D.A.V.E.

	Jun	Jul	Aug	Sep
New Call Logged (D.A.V.E.)	163	223	263	459
New Call Logged (Phone)	8889	9258	8021	9259
New Call Logged (Portal)	3214	3209	3045	3291
Updates from User (D.A.V.E.)	16	25	52	53
Updates from Desk (ITSM – D.A.V.E.)	86	281	178	257
Updates via Phone	538	472	515	579
Approvals (D.A.V.E.)	17	76	39	58
Approvals (E-Mail)	354	442	325	509
Customer Survey (D.A.V.E.)	303	503	477	553
Customer Survey (E-Mail)	704	582	462	383

This has translated to time saving efficiencies:

Average time to log a call reduced from six minutes to just one – saving staff five minutes per call
No. of hours and staff costs reduced based on total number of calls logged via D.A.V.E.

	Jun	Jul	Aug	Sep
Total Hours Saved	14	19	22	38
Clinical Hours Saved	4.2	5.7	6.6	11.4
Total Cost Saving	£3,654	£5,302	£6,408	£10,165

Average time to update a call reduced from three minutes to just one – saving staff two minutes per call
No. of hours and staff total cost reduced based on total updates of calls logged via D.A.V.E.

	Jun	Jul	Aug	Sep
Total Hours Saved	3.4	10.2	7.7	10.3
Clinical Hours Saved	1.0	3.1	2.3	3.1
Total Cost Saving	£887	£2,846	£2,243	£2,755

The use of Co-Pilot Studio for uses similar to D.A.V.E. to exploit any time saving opportunities will be prioritised in 2026-2027.

Opportunities with AI are vast and constantly changing and improving at a very fast pace. The Trust needs to ensure that any adoption of AI is safe, following the correct governance and review. This oversight is currently being provided by the AI and RPA Steering Group, and any transformation is reliant on the safe use and adoption by Trust staff.

Areas of focus for 2026

Key areas of focus for the 2026 include:

EPR Procurement and Readiness

a) EPR procurement in collaboration with Warrington and Halton Teaching Hospitals NHS Foundation Trust
b) Continuation of current EPR optimisation and future readiness – current and future state mappings, clinical and operations process standardisation, preparation for data migration, data archive strategy

Digital Strategy Review

Ensure our strategy aligns with ICB Digital Strategy

Commissioning Intentions

- Build strong Digital & Data Foundations (e.g. cyber security & resilience, data quality, clinical safety, core Electronic Patient Record solutions etc.)
- Design & deliver 'at scale' digital & data architecture & infrastructure that fully aligns with national developments & provides a core infrastructure platform across the whole of our system to support delivery of the 10 Year Health Plan ambitions
- Deploy 'at scale' digital & data platforms, tools & services (e.g. Shared Care Records, Neighbourhood Health Platform, Strategic Commissioning Tool, AI tools, NHS App integration with NHS Provider solutions, digital diagnostics tool etc.)
- Ensure all parts of our health & care system deliver the digital & data requirements outlined in the NHS Medium Term Planning Framework

What do these commissioning intentions mean?

- All NHS Providers complete Electronic Patient Record (EPR) procurement & implementation as soon as possible
- Confirm high priority 'use cases' for Shared Care Record rollout & use & deliver against highest priority requirements
- Agree future state digital & data infrastructure to meet the requirements of the 10 Year Health Plan & operationalise processes to design & build 'at scale' system wide digital & data infrastructure & capabilities, prioritised over a multi-year programme of work
- Build out of the existing FDP deployment to deliver further 'at scale' tools & services to support population health management & other core requirements of the Data into Action programme
- Taking a consistent, system-wide population health management approach to patient segmentation & risk stratification (we currently are fully compliant as we have CIPHA in place however C&M is a national incubator site for PHM for FDP)
- Rollout 'at scale' Ambient Voice Technology (AVT) solution across the system & deliver productivity benefits across clinical pathways & in various clinical settings
- Pilot Agentic AI technology in the Elective Care programme to automate waiting list management
- In conjunction with the Provider Collaborative, deploy 'at scale' clinical AI solutions into Clinical Networks including Radiology
- Confirm transfer of existing GP IT services from current service providers into the 'future state' service function
- Develop business case & start delivery of a programme to consolidate digital & data services across C&M to support high quality service delivery & underpin 'at scale' transformation work. Initial focus will be on consolidating contracts & developing shared assets (including networks & data centres)
- Optimise the use of the C&M wide Single Referral Management System supporting independent sector referral management & investigate opportunities to utilise this system in other care settings & for other purposes
- Implement single C&M Order Communication Solution, Laboratory Information Management System (LIMS) & Single Booking System for diagnostic tests

Fig 1 - ICB Commissioning Digital & Data Intentions (November 2025)

MWL is not only aligning but is driving many of the ICB Digital Ambitions including:

- Leading on the increasing digital maturity within the pathology services including implementing and hosting a single order communications solution and LIMS (Laboratory Information Management System), with the intent to improve pathology service for our patients by reducing the need for duplicate tests and sharing results across all of the care settings within C&M to enable that faster diagnosis and treatment
- Manages and provides day to day support for the CIPHA (Combined Intelligence for Population Health Action) and Shared Care Record solutions further supporting the shared information across all care settings.

Operational Transformation – Digital Enablement

Outpatient Improvement and Transformation

Outpatient Improvement remains a critical organisational priority for 2026, and the Digital Services team is fully committed to enabling the next phase of transformation. The Trust's Outpatient Improvement Programme has already identified substantial opportunities to improve productivity, increase capacity, reduce avoidable cancellations, and modernise the patient experience. Digital is deeply aligned to this work and will play a central role in providing the technical foundations, data insight, and digital tools required to drive sustainable improvement across all specialties.

During 2026, Digital Services will work in partnership with clinical, operational and performance teams to support the standardisation of outpatient workflows, the redesign of clinic structures, and the consolidation of booking processes across both PAS instances. Key areas of contribution include:

- establishing a unified digital clinic structure and modernised outcomes framework within CareFlow;
- supporting the Patient Engagement Platform (PEP) expansion across all sites;
- enabling improvements in DNA reduction, PIFU utilisation and remote consultation models;
- providing the data and dashboards required to monitor clinic utilisation, activity and adherence to Patient Access Policies;
- supporting clinic data cleansing, undisposed attendances reduction and operational housekeeping standards; and
- preparing for EPR functional design to ensure outpatient models are optimised ahead of go-live.

Digital will also continue to strengthen its analytics capability to underpin outpatient improvement, including the development of a refreshed Power BI outpatient dashboard, enhanced data quality processes, and integrated reporting across STHK and S&O sites. This insight will directly support job plan reviews, capacity modelling, clinic utilisation improvement and Further Faster projects across multiple specialties.

As the programme progresses, Digital will act as a core enabler—ensuring that new outpatient processes, clinic rules and access models are fully embedded in digital systems, aligned to the forthcoming EPR, and underpinned by reliable data, improved interoperability, and a modern digital operating environment. This partnership approach will ensure the Trust continues to make measurable improvements to productivity, patient access, and overall outpatient experience.

There are a number of key AI initiatives that the Trust is going to focus on in the next 12 months including:

Ambient Voice Technology (AVT) has the potential to truly transform the administrative functions relating to patient consultations. The technology does not just listen to a consultation, constructing the appropriate clinical notes to enable an automated letter creation but it can also trigger other processes, vastly reducing the administrative burden following a patient consultation. The Trust is about to embark on a pilot with 30 consultants within Dermatology and Trauma and Orthopaedic specialities. The Digital Team will be working closely with Clinical and Operational Teams to design a safe process to exploit the potential of this AI solution.

Following the review of the initial pilot the Trust has the opportunity to use licenses which are being purchased by the ICB using national funds. The intent is to use these licenses to fund an extended pilot for 12 months to allow the Trust the time and space to continue to develop the process and embed the use of AI whilst it reviews the capabilities and suitability of use of other AVT solutions as and when they become available. The greatest impact of an AVT solution will be one that is fully integrated within the EPR, the ambition is to work with our EPR supplier (System C) to also pilot their solution, which will be fully integrated to the EPR solution, once it is available (expected March 2026).

Tideway (Theatre Scheduling) is a suite of Copilot Agents designed in-house (MWL) to improve theatre list planning and to standardise/strengthen end-of-list debriefs. Two modules have currently been developed using Copilot. The List planning module and the Debrief module. These provide structured

decision support for planning and a lightweight digital capture of debrief themes after a theatre list concludes.

The aims and scope are to increase predictability and throughput of elective theatres by improving list planning effectiveness. Capture recurrent flow blockers systematically via a short, structured, post-list debrief so issues can be aggregated and acted upon, and provide transparent, auditable summaries that inform operational decisions. Tideway will not replace clinical judgement and is not used during direct patient care episodes

Robotic Process Automation is the process whereby we take a repetitive process, which is always the same and currently done manually and create a ‘robot’ to do the work. The trust has a very mature RPA team in place within the HR team and work this year has started to develop the capabilities through a virtual team model to introduce RPA into the clinical and other corporate teams. So far, workshops have taken place with Pathology and Finance Teams to identify RPA opportunities and development will begin on these in early 2026.

Progress Against Strategic Objectives – November 2025

The following sections summarise progress across all domains of the Digital Strategy as at November 2025, fully incorporating operational and technical updates supplied by digital, operational and clinical teams.

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Single EPR				
Single EPR Procurement	Procurement of a new EPR to replace our two current EPRs, following public sector procurement regulations.	The Trust is now designing a collaborative EPR re-procurement with Warrington & Halton Teaching Hospitals NHS FT for a single shared-instance EPR. This will include critical care and Trust-wide functionality (amongst other areas).		Procurement to start Jan 2026
Single EPR Deployment	Implementation of our new single EPR, to replace all our current functionality and level up across sites.	This new single EPR will replace all current EPR functionality and provide a standardised, interoperable clinical record across all sites. Deployment sequencing aligned to convergence roadmap and readiness plans.		
Critical Care Solution	Implementation of specialist functions to replace paper processes in our critical care units as part of our single EPR implementation.	Specialist Critical Care digital functionality will be delivered as part of the single EPR deployment.		

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Optimising our Existing Clinical Solutions				
Systems Convergence	Review all duplicate clinical digital systems and develop a strategy for convergence for each to a single Trust wide solution. Align the plan with the single EPR implementation and clinical service transformation plans.	Systems convergence roadmap will be produced as part of EPR mobilisation. Review will include EDMS, cancer tracking (Somerset), duplicate documentation systems and standalone modules As part of the EPR implementation, a roadmap will be developed to understand duplicate and stand-alone system convergence, ensuring alignment to a single EPR and removal of duplicate systems (e.g. document management systems, Somerset cancer tracking etc)		June 2026
Digitisation of Patient Records and Clinical Pathways	An accelerated programme of work to fully digitise end-to-end clinical workflows to improve patient safety and care delivery efficiency in advance of a single EPR.	The CareFlow Narrative system is now live across the trust; a programme of standardisation and deduplication of digital documentation will be developed. This will be driven and prioritised by Clinical and Operational teams. This will support ongoing EPR readiness as well intra- trust working. Similarly, Connect roll out continues with focus on standardisation of process across the trust.		Work will continue throughout 2026-2028

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Extend Pharmacy to Southport and Ormskirk Sites	The replacement of the current Pharmacy system on the Southport and Ormskirk sites, adopting the system used on the Whiston and St Helens sites.	Significant Proof of Concept (POC) work is underway to test a single EPMA solution across the Trust. Testing completes November 2025; subject to success, full deployment will commence. If testing of the POC is not successful, then deployment of EPMA to S&O is likely to be delayed		Nov/Dec 2025
Clinical Narrative Expansion	Enhancing our current EPRs, data input and access processes to reduce duplication of effort. Enhancing interoperability with other clinical systems to ensure data is captured once and used many times.	Narrative went live at S&O in September 2025		Complete at S&O in September 2025
CareFlow Handover of Care Letters & To Take Out (TTO) Prescribing Information	Migration away from the ICE and EMIS Secondary care solutions used for the production of in-patient handover of care letters to the production of these from our current CareFlow EPRs.	A pilot to automate the TTOs within EPMA will commence at the end of December 2025; Rollout will follow successful pilot evaluation.		March 2026

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Clinic Letters & Reconfiguration at STHK	Outpatient clinics rebuild and process redesign to enable the production of clinic letters in the current Careflow EPRs and the decommissioning of the current solution. Modernise and streamline outpatient booking processes across the Trust in advance of a single EPR.	Analysis of this, and potential solution within the functional capability of the existing EPR and capacity and benefit of doing pre single EPR deployment; a full programme of work needs to be developed to drive the OP Clinic reconfiguration work at STHK. Path to green - Funding and resource requirements, as well as programme plan needs to be agreed with Operational teams		Option appraisal March 2026
Theatre Management Solution	Implementing a Trust wide Theatre Management Solution to replace the obsolete system on the Whiston and St Helens sites and replace the remaining paper processes on the Southport and Ormskirk sites.	Agreed to continue with separate instances of Theatre Management Solutions. To mitigate any risks, Careflow connect has been deployed within theatres at S&O; initial assessment work is starting to review the theatre listing and pre-op processes at STHK to align them with S&O. Path to green - needs full analysis and process mapping, then agreement of standard process across the trust and prioritised		Option appraisal and plan March 2026
Pre-operative assessments	Providing functionality to digitise pre-operative assessments, implementing initially on our Southport and Ormskirk sites and extending to all sites in line with the roll out of the Theatres solution.	This will be delivered as part of the BlueSpier upgrade at Southport and Ormskirk – pre-operative assessment is live within the S&O instance of Narrative; the decision was taken to not utilise the BlueSpier functionality at this time		Complete at S&O in October 2025

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Maternity	Replace the current CareFlow Maternity system with the Badgernet solution to support the provision of electronic notes held by the pregnant person (‘red book’ notes) and accessed via a mobile phone app.	Significant work has been ongoing to build and deploy a single instance of the Badgernet Maternity Solution across the trust; there have been operational pressures that will potentially delay the deployment of the system to later in 2026. Path to green - Requires accelerated input from the Clinical Team around design decisions to enable the build of the solution. Clinical teams need to plan to release staff for training p		March 2026
Order Communications and laboratory processes optimisation	Fully deploy order communications across the organisation and review and modernise laboratory process on our Whiston, St Helens and Newton sites.	The use of electronic ordering / resulting has been reviewed and issues identified which are impacting the process going fully paperless. The paper will be reviewed with lab and operational colleagues and an action plan agreed. Work is ongoing to enable the lab results to be available within the S&O instance of Careflow and allow the removal of the ‘Review’ product. This will mean orders and results can be actioned through the S&O instance of Careflow. Path to Green - Requires further clinical engagement to change their current processes Potentially move into the scope of the EPR readiness programme		Date to be reviewed in line with the EPR readiness programme

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Patient Portal	Roll out and development of our patient portal to provide patient access to their letters, appointment management functions, condition specific information, completion of questionnaires and direct communication with care professionals. Aligned with our current EPRs and our new single EPR.	Live across all S&O services. At STHK, Waiting List Validation functionality is live. Wider deployment at STHK dependent on OP rebuild. Analysis of this, and potential deployment within the functional capability of the existing EPR and capacity and benefit of doing pre single EPR deployment. Path to green is dependent on STHK OP clinic reconfiguration		March/April 2026. (NB. Deployment at STHK dependent on OP clinic rebuild).
Digital Dictation	Replace our currently unsupported digital dictation solution at the Whiston and St Helens sites until speech recognition is implemented.	This has been fully deployed across the STHK site and is now in BAU state		Complete
Speech Recognition	Speech enabled direct entry of information into the patient record in real time to reduce data input effort and streamline the production of clinic outcome letters.	This objective has been superseded by the Ambient Voice Technology programme		N/A
Care Records Document management system review	Develop a strategy for the convergence of our two Electronic Document Management Solutions (EDMS) to deliver a single point of access for digitised copies of paper care records. Set out a roadmap for a single solution in alignment with the single EPR programme.	This will be considered as part of the post EPR deployment, optimisation strategy		To be determined (likely to be post EPR optimisation work programme)

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Community Care Record Optimisation and Consolidation	Develop plans to move to a single community care records system. Optimise our existing solutions to remove paper from community care processes.	The community care records are halfway through moving to a single solution. Further work and investment need to complete the programme Path to green – Understand resourcing and costs to migrate to a single community system.		2026/27
Community order communications, results reporting and prescribing	Implement laboratory order communications and results reporting will be aligned with our single Regional Order Comms Electronic prescribing and medicines administration for our community teams	Community order comms is dependent on the Regional LIMS and Order Comms programme E-Prescribing is live with 3 services in EMIS (Frailty, UCR/Virtual ward) and will be deployed to community matrons in Nov 2025; Future releases of EMIS will enable linkage to EPMA.		2028 2026
Corporate RPA initiatives	Moved to the AI/Automation Programme			
ICS Workstreams				
Clinical Network Support Regional LIMS	Support the development and deployment of a regional Laboratory Information Management System (LIMS).	Implementation of regional LIMS is ongoing, MWL are leading on this; go live planned for mid 2027		Go live planned for March 2027
Regional Integration	Aligning with regional initiatives to increase interoperability for diagnostic services and other regional systems. Work is currently in the planning stage.	As part of the LIMS programme a new Regional Integration Engine has been built. This will initially be used for LIMS but then further use to other diagnostic services will be explored.		2028-29

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Cheshire & Mersey Shared Care Record	Migrate the current St Helens Care Record to the Cheshire & Mersey Care Record solution in line with the ICS digital strategy.	Completed		Complete in July 2024
Regional Clinical Network Support	Aligning with regional initiatives to increase interoperability for clinical networks and general practice communications.	This is a 'catch all' to cover the Trust's involvement in various ICB-wide initiatives. For example, in addition to LIMS mentioned above, we are involved with a single ICE across C&M, a single endoscopy solution and the Federated Data Platform.		Ongoing
Technology Workstreams				
Data Centre and Server Upgrades	Implement new on-premises server and storage infrastructure equipment in the Trust's two main data centres.	The data centre and server upgrades has been completed		Completed in Feb 2025
Trusted Network Domain Status	Increase the level of sharing between our two current networks to a 'Trusted relationship' status so that whilst separate, they appear to be as one.	The Trust relationship between the two domains has been completed		Completed in April 2024
Remote access capability	Provide a new single solution to enable consistent and reliable remote access to our systems and services supporting our homeworkers.	Single remote access solution now utilised across all sites for home/remote workers.		Completed in May 2024
Single Firewall	Migrate to a single firewall and cyber security processes to further protect the Trust from cyber security threats.	All of the workloads have been migrated to single firewall (internet traffic, VPN)		Completed in Feb 2025

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Single Digital telephony	Implement a single digital telephony solution replacing our current obsolete solutions to improve reliability and provide a modern capability.	Not yet started	Not started	Scheduled to take place in 2026/2027, with funding identified within the draft capital plan
Single Domain Network	Migrate fully to a single domain network – the final step for providing a solid foundation upon which all our digital systems and services are provided.	Business case is being developed to secure the funding to carry out this piece of work	Not started	To be scheduled in 26/27
Rolling device replacement	Maintain our laptop, desktop and handheld device refresh programme (if affordable) so that no device is over 5 years old.	Rolling programme still underway – due to availability of funding, device replacement is now for any over 6 years old. All kit that was incompatible with Windows 10 was replaced well in advance of the date when it became out of support in October 2025 RAG'd amber due to the investment needed in 2026-2027 – this exceeds other years investment amounts		Ongoing, programme in place every year
Single Sign on	Integrate more applications into our Single Sign-on solution to reduce the need for multiple system logins.	Any news systems are implemented with Single Sign On, and strategy includes new systems requiring integrating with existing identity sources.		Work will continue through the domain consolidation project expect to be completed by the end of 2027
Standard device build	Roll out a standard build for all our access devices to streamline technical support requirements which will make it easier to move devices between sites.	There is a dependency on Single Domain Network. Not yet started.	Not Started	Estimate to start in 26/27

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
Bring Your Own Device	To reduce the need for multiple devices and to improve the user experience of our staff.	BYOD items have been added in to the acceptable use policy and communicated at relevant groups. All Microsoft 365 applications such as email and teams are available from personal devices. Some clinical applications, such as Careflow Connect, are available for use from personal devices.		Potential for continued promotion of this but the technology was completed in July 2025
Email Migration	Complete the migration of all our email addresses to the trust address.	All staff have been moved from the legacy sthk.nhs.uk addresses to the merseywestlancs.nhs.uk address		Completed Jan 2025
Single Integration Engine	Move to a single provision of the technology that allows us to exchange data between our clinical systems.	This has not yet started, plan to implement it in 26/27 but will review in line with the regional integration engine	Not Started	Estimated date 2026/27
Single Monitoring Tools	Single monitoring solutions and tools for the management of all our infrastructure and services.	All monitoring tools have now been consolidated providing a single pane of glass for detecting and troubleshooting issues across all sites. Complete		Completed May 2024
Integrated Technology Team	Move to a single team, focussed on building the specialist technical skills required to achieve our strategic aims.	The team mergers have been completed across Informatics		Completed in April 2024
AI & Automation Workstreams				
AI and Automation	AI & Automation Programme	Steering Group established; governance drafted and shared for approval		Ongoing
	Ambient Voice Technology (AVT)	Pilot due to commence Dec 2025/Jan 2026.		Pilot start Dec 2025/Jan 2026

Strategic Development	Description	Update – November 2025	RAG Status	Forecast date
	Microsoft Copilot	Copilot Web piloted by small group. Copilot for Theatre Scheduling (Tideway) pilot to commence in January 2025.		Jan 2025
	RPA	All Blue Prism bots rebuilt; Blue Prism platform scheduled for decommissioned		March 2026
	Continue to deploy Robotic Process Automation (RPA) technologies in corporate services to automate repetitive tasks.	There have been many processes that have been automated within HR. The AI / Automation Steering Group has picked up the further development of RPA across the Trust, with a programme of work to be determined.		Bot-athons planned for January 2026, however, likely to be an ongoing delivery programme throughout 2026-2028

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	26 November 2025
Agenda Item	**TB25/092**			
Report Title	Trust Board Meeting Arrangements 2026/27			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

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

Executive Summary

1) Board meetings have been held on the last Wednesday of each month, and it is proposed that this arrangement will continue during 2026/27.
2) The paper confirms the dates for agenda setting, collation and distribution of papers and of the actual meetings.
3) The Board work plan, to schedule agenda items throughout each year, has been reviewed to ensure that it meets all statutory requirements and delivers the duties and responsibilities in the Trust's standing orders.
4) This meeting schedule, once approved, is used to inform the dates and work plans of the Board committees
5) The Board work plan may be further amended following the annual board effectiveness review that is conducted between January and April each year or considering any new statutory or regulatory requirements before the beginning of the 2026/27 financial year.

Financial Implications

None directly from this report.

Quality and/or Equality Impact

Not applicable

Recommendations

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

Strategic Objectives

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

SCHEDULE OF TRUST BOARD MEETING DATES (2026/27)

1. Meeting Schedule

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

1.2. The Trust believes in being open and transparent and members of the public can observe the public section of each Board meeting, via MS Teams link. Members of the public can also submit questions to the Board, in advance of the public board meetings. Public Trust Board Meetings will commence at 09.30 and will be planned to run for two to three hours each.

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

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

2. Administrative Arrangements

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

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

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

2.4. The following table captures the schedule for the 2026/27 Financial Year. Meetings that include a strategy session are shaded grey.

Financial Year 2026/27	Agenda setting	Call for papers	Deadline for receipt of papers	Papers to be distributed	Electronic Copies on Intranet	Date of meeting
April 2026	Thu 26 March 2026	Fri 27 March 2026	Tue 21 April 2026	Fri 24 April 2026	Tue 28 April 2026	Wed 29 April 2026
May 2026	Thu 30 April 2026	Fri 01 May 2026	Tue 19 May 2026	Fri 22 May 2026	Tue 26 May 2026	Wed 27 May 2026
June 2026	Thu 28 May 2026	Fri 29 May 2026	Tue 16 June 2026	Fri 19 June 2026	Tue 23 June 2026	Wed 24 June 2026
July 2026	Thu 02 July 2026	Fri 03 July 2026	Tue 21 July 2026	Fri 24 July 2026	Tue 28 July 2026	Wed 29 July 2026
August 2026	NO MEETING					
September 2026	Thu 03 September 2026	Fri 04 September 2026	Tue 22 September 2026	Fri 25 September 2026	Tue 29 September 2026	Wed 30 September 2026
October 2026	Thu 01 October 2026	Fri 02 October 2026	Tue 20 October 2026	Fri 23 October 2026	Tue 27 October 2026	Wed 28 October 2026
November 2026	Thu 29 October 2026	Fri 30 October 2026	Tue 17 November 2026	Fri 20 November 2026	Tue 24 November 2026	Wed 25 November 2026
December	NO MEETING					
January 2027	Thu 17 December 2026	Fri 18 December 2026	Tue 19 January 2027	Fri 22 January 2027	Tue 26 January 2027	Wed 27 January 2027
February 2027	Thu 28 January 2027	Fri 29 January 2027	Tue 16 February 2027	Fri 19 February 2027	Tue 23 February 2027	Wed 24 February 2027
March 2027	Thu 04 March 2027	Fri 05 March 2027	Tue 23 March 2027	Fri 26 March 2027	Tue 30 March 2027	Wed 31 March 2027

3. Proposed Trust Board Work Plan (2026/27)

The work plan is provisional pending the annual Board and Committee effectiveness reviews which will be conducted between January and April, the results of which are presented to the Board in May.

ANNUAL TRUST BOARD CALENDAR 2026/27 (DRAFT)

Month			A	M	J	J	A	S	O	N	D	J	F	M	Report	Presenter
Scheduled agenda items	General	Employee of the month	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Dep CEO	Chair
		Patient story		✓		✓		✓		✓		✓		✓	CNO	Various
		Apologies	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Declaration of interests	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Minutes of the previous meeting	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Action list / matters arising	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Meeting Effectiveness Review	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Any other business	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
	Committee Reports	Audit (inc approval of Corp Governance Manual and Standing Financial Instructions)	✓	✓				✓	✓				✓		CFO	NED
		Executive	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	DofCS	CEO
		Finance and Performance	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	CFO	NED
		Quality (inc Safer Staffing, Maternity and Infection Control)	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	CNO	NED
		Strategic People Committee	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	CPO	NED
		Charitable Funds			✓				✓				✓		CFO	NED
	Operational performance reports	Integrated performance report	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	CFO	
		Corporate Risk Register	✓			✓			✓			✓			DofCS	
		Board Assurance Framework	✓			✓			✓			✓			DofCS	
		Aggregated Incidents, Complaints and Claims report		✓		✓			✓			✓			CNO	
		Informatics Report and Strategy update								✓					Dof Inf	
		Learning from Deaths Quarterly Report and Annual Report (July)	✓			✓			✓			✓			Chief Medical Officer	
		Maternity and Neonatal Services Assurance Report		✓						✓					CNO	
	Annual reports	Approval of the Annual Accounts			✓										CFO	
		Approval of Quality Account		✓											CFO	
		NHS Licence Conditions Board declarations			✓										DofCS	
		Board and Committee Effectiveness Review		✓											DofCS	
		Cyber Assessment Framework (CAF) Toolkit Results and Information Governance Annual Report				✓									Dof Inf	
		Trust objectives approval & mid year review		✓						✓				✓	DofCS	CEO
		Medical revalidation annual declaration						✓							Chief Medical Officer	
		Audit Letter sign-off						✓							CFO	
		Charitable Funds Accounts & Annual Report							✓						CFO	
		Research & Development Annual Report								✓					Chief Medical Officer	
		Research & Development Annual Capability Statement								✓					Chief Medical Officer	
		Biennial Review of NHS Constitution (next scheduled for 2026)								✓					DofCS	
		Trust Board meeting arrangements								✓					Dof CS	
		EPRR Annual Report				✓									COO	
		EPRR Compliance statement						✓							COO	
		WRES & WDES Reports and Action Plans							✓						DofHR	
		Clinical Strategy annual update							✓						Chief Medical Officer	
		Safeguarding Annual Report (Adult & Children)			✓										CNO	
		Operational Plan - Budget and activity approval										✓		✓	DoF/COO	
		National Quality Board - nursing w orkforce plan/staffing review	✓							✓					CNO	CPO
		Infection Control Annual Report				✓									CNO	
		CQC registration												✓	CNO	
		Mixed sex annual declaration												✓	CNO	
		Fit and Proper Persons Chair's Annual Declaration			✓										DofCS	Chair
		Freedom to Speak Up - Board Self Assessment and Annual Report											✓		CNO	
		CNST MIS Self Declaration & Approval *(allocate 30 minutes on 2026 agenda)*										✓			CNO	
		Pay Gap Annual Declaration						✓							CPO	
		Staff survey report and action plan												✓	CPO	
		Health Inequalities Strategy Annual Review		✓										✓		
		NHSE Oversight Framework – Provider Capability Self-Assessment			✓										DofCS	CEO
		NSHE New Experience of Care Framework Annual Update / Self-Assessment	✓												CNO	
		Total scheduled items	18	20	18	20	0	18	21	21	0	19	15	19		
Closed Session	Chair and NED meeting (or as required)		✓		✓				✓				✓		Chair	
	Chief Executives report			✓		✓		✓		✓		✓		✓	CEO	
	Patient Safety Incident Investigation Report			✓		✓		✓		✓		✓		✓	CNO	
	Suspensions			✓		✓		✓		✓		✓		✓	CPO	
	Cyber Security Assurance Report			✓				✓		✓				✓	DofInf	
	NHSE Oversight Framework – Provider Capability Self-Assessment			✓											DofCS	CEO
	Feedback from external meetings and events			✓		✓		✓		✓		✓		✓	All	
	Review of meeting effectiveness			✓		✓		✓		✓		✓		✓	Chair	

Title of Meeting	**Trust Board Meeting**		**Date**	26 November 2025
Agenda Item	**TB25/093 (13.1)**			
Report Title	2024/25 Research Development and Innovation (RDI) Annual Report			
Executive Lead	Dr Simon Dowson, Chief Medical Officer			
Presenting Officer	Dr Simon Dowson, Chief Medical Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

To brief the Trust Board on the Research Development and Innovation (RDI) Annual Report which provides an overview of reported RDI activity in the Trust for 2024/25.

Executive Summary

It has been another successful year for the Research Teams at MWL. We have opened and expanded Research Hubs across the organisation (Whiston, Ormskirk and Marshalls Cross). We have worked with key partners from the NHS, Higher Education Institutions and external commercial companies to ensure that we increase opportunities for our patients. By working collaboratively, we will help to shape the future of our health services and treatments, through taking part in research.

In total MWL staff have recruited 2,046 participants to research studies since 01 April 2024, this has placed MWL in eighth position on the new Research Delivery Network, North West (RDN NWC) dashboard. Since the merge of the two Networks the number of organisations has increased from 21 to 31 which means that achieving eighth position is an exceptional achievement.

Once again, we were top of the National Institute for Health and Care Research (NIHR) Patient Research Experience Survey dashboard by some distance. Patient feedback is crucial to us; it helps us to understand if any improvements in our service are required. It was pleasing to note that most of the feedback was positive, knowing that our patients are having the best experience is something that we are very proud of.

During 2024/25 MWL were top recruiters in a number of specialties across the Regional Research Delivery Network (RRDN). This demonstrates our commitment and hard work to ensure our patients are offered the opportunity to take part in cutting edge research.

Our performance with regards to meeting the predicted recruitment to time and target for non-commercial studies was over 80%, and 50% for our commercial studies.

Our cancer team have been extremely busy, 129 patients with cancer took part in cancer research. This is in addition to those who are in long term follow up and remain on their study schedule. The team has worked consistently hard to ensure that clinical trials are embedded in the multi-disciplinary team (MDT) meetings as part of the decision making around patient treatment options. All of this benefits our patients and allows them access to the latest cancer treatments.

In 2024 MWL were notified that we had been successful in a bid to become one of its ten spoke organisations of the newly formed NIHR Commercial Research Delivery Centre (CRDC). We have started working with the NHS University Hospitals of Liverpool Group (UHLG) who are in the process of setting up the systems and processes required to run the CRDC.

We have provided finance and study support to Marshalls Cross GP surgery with the aim of encouraging and expanding research at the practice.
Financial Implications
The National Institute for Health Research (NIHR) funding envelope, for staff pay, hasn't increased in recent years therefore, we cannot expand and grow the number of NIHR funded staff.
Quality and/or Equality Impact
Not applicable
Recommendations
The Trust Board is asked to note the 2024/25 Research Development and Innovation (RDI) Annual Report.

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Annual Report 2024/2025

Produced - May 2025
Published - June 2025

Lead Authors: Mrs Jeanette Anders – Whiston, St Helens & Newton Site (WSN)
Mrs Jillian Simpson – Southport and Ormskirk Site (S&O)

FOREWORDS

The purpose of this Research, Development and Innovation (RDI) Annual Report is to present information to the Trust Board on the full year RDI activity for 2024/2025. The report provides the evidence that Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) maintains and develops their statutory duty to "Promote Research, Innovation and the use of research evidence (Health and Social Care Act, 2012)[1]". It provides an update on the key aspects of progress, performance, and financial management. It also includes an overview of achievements in relation to research activity at MWL.

The NHS benefits greatly from delivering research directly, not only in terms of breakthroughs enabling earlier diagnosis, more effective treatments and improved system design, all of which improve patient care and health outcomes, but also increased workforce satisfaction and retention and patient and carer experience. Mortality is lower in research active hospitals. The NHS also benefits financially from delivering research. The purpose of the Embedding Research team in NHS England is to enable the NHS to increase the scale, pace and diversity of those taking part in research and to provide system guidance and assurance[2].

Our Vision at MWL is that Clinical Research and Innovation is of critical importance, and our aim is to align with regional and national strategies to deliver high quality evidence-based medicine. It is through Research and Innovation that new clinical services and treatments can be evaluated, improved and effectively implemented, to improve patients' care and experience. The Trust's participation in Research and Innovation allows our patients to access such benefits.

MWL has two research sites:

- **WSN Site** (Whiston, St Helens, Newton Hospitals, Marshalls Cross Surgery and Community Services)
- **S&O Site** (Southport and Ormskirk Hospitals)

Dr Peter Williams, Medical Director

"It has been an incredibly exciting year for the MWL Research, Development, and Innovation department. In 2024, we were proud to open new Research Hubs at Ormskirk Hospital and Marshalls Cross GP Surgery, alongside expanding our existing Research Hub at Whiston Hospital. These state-of-the-art facilities provide a safe, welcoming environment for patients to become involved and participate in research, playing a key role in the Trust's continued success in advancing medical science.

As part of our ongoing commitment to improving healthcare, the Trust has also become a partner in the newly established Cheshire & Merseyside Clinical Research Delivery Centre (CDRC). This initiative will significantly increase opportunities for our patients to participate in groundbreaking treatments and clinical trials. The Commercial Research Delivery Centres (CRDCs) are set to act as regional hubs for innovative clinical trials, offering access to pioneering treatments supported by the latest technology.

I would like to take this opportunity to express my deepest gratitude to both our patients and the dedicated staff members involved in clinical research. Without their unwavering support, we could not continue to drive forward the delivery of research and ensure the very latest innovative treatments are available to those we serve."

Dr Ascanio Tridente, Clinical Director of RDI at Whiston, St Helens and Newton site

2024/25 has been another extremely successful year for Research, Development and Innovation at MWL. The Organisation greatly enhanced its ability to deliver research by opening and expanding three research hubs, and has seen a huge expansion in recruitment, greatly surpassing our pre-established internal targets. The Trust ranks very high in the newly formed Regional Research Delivery Network, while improving recruitment across both commercial and non-commercial portfolios of research. MWL remains the Trust with the highest number of responses and exceptional performance in the Patient Research Experience Survey, across the network. Feedback is overwhelmingly positive. The two legacy Organisations, following merger, continue to harmonise processes, to improve performance and deliver the best experience, opportunities and care for our patients. These superb results

would not have been possible without the dedication, commitment and incredible hard work of our extremely professional and devoted research staff. We acknowledge the importance of high-quality research for our patients, and we celebrate the success of RDI at MWL, as a very research active organisation. I, once more, want to express my gratitude to all those involved in supporting these great endeavours.

Dr Craig Rimmer, Deputy Clinical Director of RDI

It is with great pride that we present the Mersey and West Lancashire Teaching Hospitals NHS Trust Research, Development and Innovation (RDI) Annual Report. This report highlights the outstanding progress made over the past year in embedding a strong culture of research and innovation across our Trust, supporting better outcomes for our patients, staff, and communities.

The past year has seen remarkable growth in our research activity, with increasing numbers of clinical trials and studies supported across our hospitals. From early-phase commercial trials to community-based research, we continue to play a vital role in shaping the future of healthcare both locally and nationally. We remain committed to ensuring that research is inclusive and accessible to all. By working closely with our communities and patient representatives, we are breaking down barriers to participation and striving to ensure that our research reflects the population we serve. The ultimate outcome of this is reflected in our participant in research experience survey responses being amongst the best in the region.

Looking ahead, our strategy is clear: to continue building a research-active culture where innovation thrives, to support our clinicians and researchers in pursuing new ideas, and to ensure that our patients benefit from the latest advances in medical science. We are confident that through sustained investment, strong academic and commercial partnerships, and a clear focus on outcomes, we will continue to deliver research and innovation that truly makes a difference.

I would like to thank all our staff, research participants, partners, and supporters who have contributed to this year's achievements. Your passion and commitment are at the heart of everything we do.

Mrs. J Anders, RDI Manager – Whiston, St Helens and Newton site (WSN)
Mrs. J Simpson, RDI Manager – Southport and Ormskirk site (S&O)

It has been another successful year for the Research Teams at MWL. We have opened and expanded Research Hubs across the organisation (Whiston, Ormskirk and Marshalls Cross). We have worked with key partners from the NHS, Higher Education Institutions and External Commercial Companies to ensure that we increase opportunities for our patients. By working collaboratively, we will help to shape the future of our health services and treatments, through taking part in research.

We would like to take this opportunity to thank all the staff who deliver and support research at MWL, our successes simply would not be possible without the hard work and commitment of everyone who undertakes and supports research.

In addition, it is vital that we thank our Research participants who are generous with their time and commitment by agreeing to take part in research. Without them important questions about future treatments and health care could not be answered or improved.

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SECTION ONE: BACKGROUND

1.1 One of the biggest changes this year was of course the election of a new government. The Labour Party's manifesto made a commitment to continue the work to implement the recommendations made by Lord O'Shaughnessy. The government has also made it clear that they want the UK to be a world leader in clinical trials and recognised the importance of life sciences to the health of the nation and growth of our economy[3]. There are a number of key external policies and changes that recognise the importance of research in the NHS and drive the research agenda nationally.

1.2 Managing research finance in the NHS 2024 - Good financial management is a key part of effective delivery of research in the NHS, and it is important to recognise that some aspects of this are niche to research and require specialist knowledge, compared to overall NHS financial management. New guidance released in April 2024 set out good practice and other information to support NHS organisations in England maintain or develop their research finance management policies and processes[4].

1.3 In October 2024 the National Institute for Health Research (NIHR) Clinical Research Networks (CRNs) were replaced with Regional Research Delivery Networks (RRDNs). The RDNs are funded by the Department of Health and Social Care (DHSC) to enable the health and care system to attract, optimise and deliver research across England. They consist of 12 Regional Research Delivery Networks (RRDNs) and a Coordinating Centre (RDNCC), working together as one organisation with joint leadership. They contribute to NIHR's mission to improve the health and wealth of the nation through research. Their vision for the UK to be a global leader in the delivery of high-quality research that is inclusive, accessible, and improves health and care.
Their mission is to enable the health and care system to attract, optimise and deliver research across England.
They have 2 primary purposes:

- support the successful delivery of high-quality research, as an active partner in the research system
- increase capacity and capability of the research delivery infrastructure for the future

This will:

- enable more people to access health and social care research where they live
- support changing population needs by delivering a wider range of research and deliver research in areas of most need
- provide support to the health and care system through research
- encourage research to become a routine part of care[5]

1.4 In December 2024 the government announced that patients across the UK will have greater access to cutting-edge treatments and clinical trials. The government announced £100 million of public-private investment to set up 20 research hubs. Commercial research delivery centres (CRDCs) will act as regional hubs for pioneering clinical trials, creating opportunities to test innovative new treatments with the latest equipment and technology. They will be established in all 4 corners of the UK - England, Scotland, Wales and Northern Ireland.
These trials will build UK research delivery leadership into all conditions across multi-specialist centres. This includes cancer and obesity, as well as infectious diseases such as flu and respiratory syncytial virus (RSV). The CRDCs will support the rapid set-up of commercial studies so patients can begin accessing treatments undergoing trials as early as possible.
In support of the 10 Year Health Plan, CRDCs will shift clinical trials into community settings, meaning those in under-served regions will be better able to participate in research. This will boost access to new treatments in the trial stage[6].

Overall, the CDRC's Vision is to help the UK become a destination of choice.

1.5 In 2025 the new rules for running clinical trials in the UK were officially signed into law. The updated regulations reflect the feedback of patients, researchers, healthcare professionals, and industry – and aim to make it easier to run safe and inclusive trials[7].

1.6 Research and Innovation are important for the UK economy, bringing jobs and services. The Government's Industrial Strategy set an ambition for R&D spending to reach 2.4% of GDP by 2028, which could see health R&D spending hit £14 billion. The Life Sciences Industrial Strategy [158] highlights that the UK is one of the best places in the world to do biomedical research, with globally renowned scientists and institutions in a rich, connected ecosystem making new discoveries every day. The government's ambition is to treble industry contract and R&D collaborative research in the NHS over ten years, to nearly £1 billion. The UK has outstanding capabilities for research and innovation: our universities and science base, leading NHS providers, genomics programme and the UK Biobank. These assets, combined with better data infrastructure, have the potential to lock in the UK as a global force in data-driven scientific advances in healthcare. The NHS endorses and will play its full part in the Life Sciences sector deal[8].

1.7 The Association of Medical Research Charities briefing paper, published in September 2024, outlines the importance of research and innovation in the NHS's 10-year health plan. It emphasizes the need to support a thriving clinical research workforce, maximize participation in research, and ensure the easy delivery of research throughout the NHS[9].

1.8 The Health Research Authority (HRA) is one of a number of organisations that work together in the UK to regulate different aspects of health and social care research. Their vision is for high-quality health and social care research that improves people's health and wellbeing, and the core purpose is to protect and promote the interests of patients and the public in health and social care research. The HRA Business Plan for 2024/2025 states that over the next three years, they will be guided by two principles. **To include**, so that health and social care research is done with and for everyone, and **to accelerate**, so that research findings improve care faster because the UK is the easiest place in the world to do research that people can trust[10].

1.9 The Health Innovation North West Coast is the Health Innovation Network for the North West Coast, which covers Cheshire, Merseyside, Lancashire and South Cumbria with a population of around 4.1 million. They connect NHS organisations, local authorities, businesses, the third sector and academia to form collaborations which support innovations and improvements in health and care. They link two integrated care boards, 20 NHS trusts, 25 local authorities and nine universities in our region[11].

1.10 The following tables display the research delivery staff funding arrangements during 2024/2025.

Tables 1-3 RDI Department Staff – MWL

Table 1	Funded by MWL	
Title	**Area**	**WTE Funded**
RDI Manager	RDI	1.40
RDI Co-ordinator	RDI	2.00
RDI Support Officer	RDI	1.00
Research Nurse	Commercial	1.00
Senior Research Nurse	Commercial	1.00
Research Nurse	Diabetes / Generic	1.00
Senior Clinical Research Practitioner	Generic	1.00

Table 2	Funded by RDN	
Title	**Area**	**WTE Funded**
Senior Research Nurse	Cancer	0.80
Senior Research Nurse	Generic	0.91
Research Nurse	Cancer	1.00
Research Nurse	Rheumatology/Generic	0.60
Research Nurse	Generic	3.20
Research Nurse	Paediatrics	1.22
Research Midwife	Maternity	1.30
Research Nurse	Critical Care/ Generic	0.60
Associate Clinical Research Practitioner	Generic	2.00
Data Manager	Cancer	1.50
Project Support Officer	Generic	1.00
Research Support Assistant	Generic	1.00

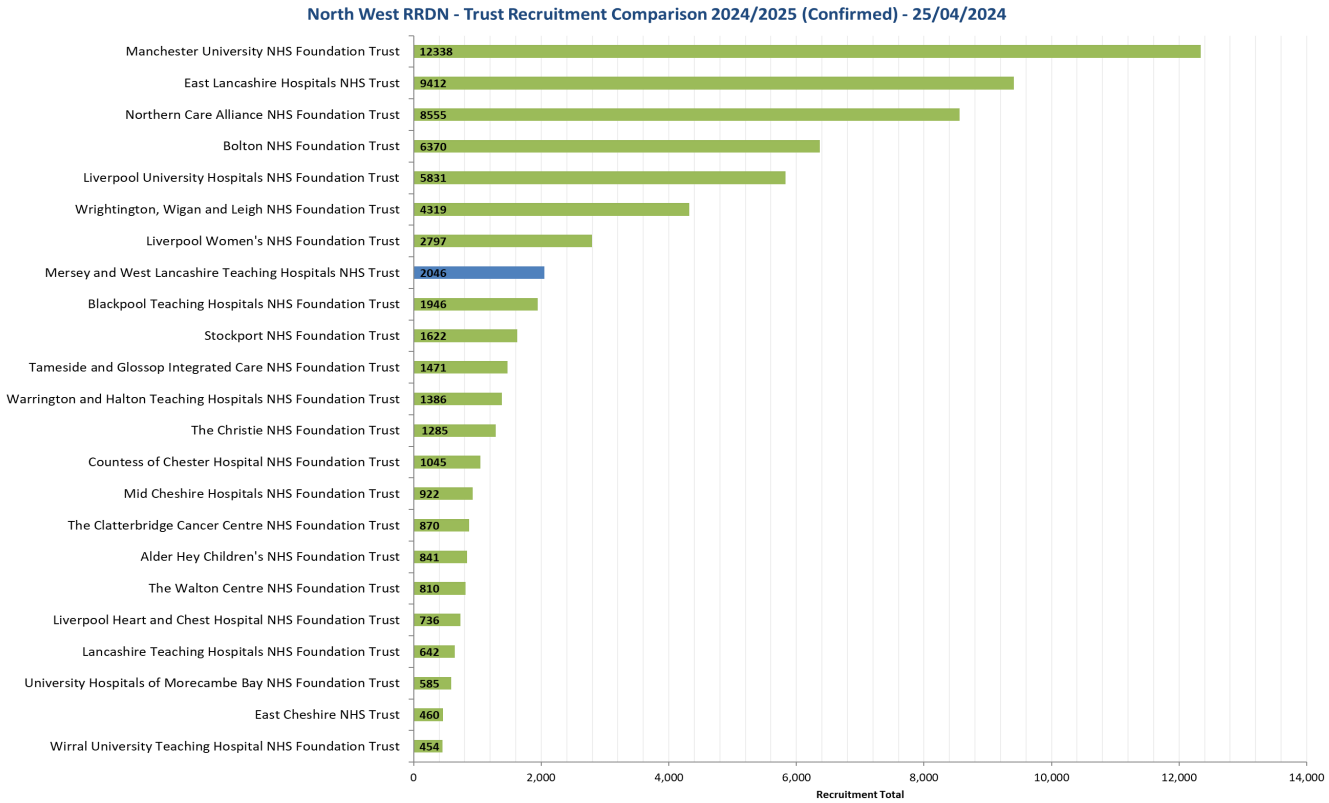
Table 3	Funded by Own Department at WSN	
Title	**Area**	**WTE Funded**
Burns Research Nurse	Burns	1.0
Stroke Research Nurse	Stroke	1.0
Senior CRP	Cross Specialty	1.0

1.11 Commercial research is defined as research that is funded and sponsored by a commercial organisation. A study is defined as industry sponsored and funded if a commercial company has developed the study protocol and is fully funding the additional costs of hosting the trial within the NHS. MWL receives income from industry-sponsored research, this income covers all costs for the study as well as overheads and capacity building. At MWL the overheads are distributed in accordance with the Trust approved Income Distribution Plan. All research income is managed centrally within RDI, with support from the Finance Department, to ensure consistency, accountability and transparency of research income and expenditure. The IDP covers both commercial and non-commercial research and includes guidance around the spending of funds after a study has closed. It states that any study funds not utilised within 12 months of the study closure or without a set plan for expenditure will be allocated to the RDI Department and reinvested in research. The IDP was produced to provide a transparent and consistent approach to the utilisation of income from research studies. The IDP was updated to allow and encourage the flow of research income to be reinvested back into research in a timely manner, thus enabling growth and expansion.

SECTION TWO: OVERVIEW / SUMMARY OF RESEARCH ACTIVITY

2.1 In total MWL staff have recruited **2046** participants to research studies since the 1st April 2024, this has placed MWL in 8th position on the new Research delivery Network, North West (RDN NWC) dashboard. Since the merge of the two Networks the number of organisations has increased from 21 to 31 which means that achieving 8th position is an exceptional achievement. Of the 2046 participants 1489 were recruited from WSN and 557 from S&O. This is the result of a huge effort from all the staff within the RDI Department; it also demonstrates our commitment to offering patients and public the opportunity to take part in research.

Chart 1 - Trust Comparison



2.2 The number of active research studies reported at MWL during 2024/2025 is as follows:

Table 4 - Number of Active studies

Site	Number of NIHR Portfolio Studies	Number of Non-Portfolio Studies	Total number of studies
WSN	107	20	127
S&O	52	6	58

See appendix 1 - a list of NIHR portfolio studies that have recruited during 2024/2025

2.3 During 2024/2025 the number of new studies assessed for Confirmation of Capacity and Capability (C&C) at WSN was n26, and n15 at S&O.

2.4 The majority of our studies, 86% (n159) were NIHR portfolio adopted studies. We also supported several non-NIHR studies 14% (n26), in some instances we provided help with sponsorship, costings/finance, Integrated Research Application and ethical approval.

Our studies range from observational to complex interventional studies; the following charts demonstrate the types of studies conducted at MWL during 2024/2025.

Table 5 - Study Categories (n127) WSN

Study Category	No. of Studies
Basic science study involving procedures with human participants	18
Clinical investigation or other study of a medical device	4
Clinical trial of an investigational medicinal product	22
Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical	40
Other study	7
Research database	7
Research tissue bank	1
Study administering questionnaires/interviews for quantitative analysis	14
Study involving qualitative methods only	5
Study limited to working with data (specific project only)	6
Study limited to working with human tissue samples	3
Total	**127**

Table 6 - Study Categories (n58) S&O

Study Category	No. of Studies
Basic science study involving procedures with human participants	6
Clinical trial of an investigational medicinal product	9
Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice	15
Other Study	2
Research database	5
Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology	9
Study involving qualitative methods only	7
Study limited to working with data (specific project only)	1
Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)	3
Other research	1
Total	**58**

2.5 In some cases the Trust takes on the role of Sponsor. The Sponsor is the individual, company, institution or organisation that takes on the ultimate responsibility for the initiation, management (or arranging the initiation and management) and/or financing (or arranging the financing) for that research. The sponsor takes primary responsibility for ensuring that the design of the study meets appropriate standards, and that arrangements are in place to ensure appropriate conduct and reporting.

The number of sponsored studies at WSN in 2024/2025 was 7 compared to 9 in 2023/2024, none of these were CTIMPs (Clinical Trial of an Investigational Medicinal Product). See table 9 below:

Table 7 - Studies Sponsored by WSN (n7)

Name	Type	Specialty
A qualitative mixed-methods exploration of the work-related factors on the psychological well-being of junior doctors in an acute hospital setting in the United Kingdom	Study involving qualitative methods only	Psychology
Breast Cancer Risk Factor Awareness at MWL	Study administering questionnaires/interviews for quantitative analysis	Cancer
Chronology in multimorbidity clustering and its effect on treatment burden and the utilisation of health and social care services - The experiences of multimorbidity patients regarding treatment burden	Study involving qualitative methods only	Trust Wide
Does early burn excision improve outcomes in patients with major burns?	Study limited to working with data (specific project only)	Burns
Impact of COVID-19 on Breast Cancer - Qualitative Study V1.0	Study administering questionnaires/interviews for quantitative analysis	Cancer
Stroke and atrial fibrillation (AF) with a focus on prevalent and incident stroke and/or AF in one area of North West England, and associated clinical risk factors, multimorbidity, time trends, and outcomes, and development and evaluation of clinical risk models and dynamic changes in stroke	Study limited to working with data (specific project only)	Stroke
The Impact of Multimorbidity and Socioeconomic Status on Health Service Utilisation Before and During the COVID 19 Pandemic	Study limited to working with data (specific project only)	Trust Wide

2.6 A key priority for the Department of Health is for the Trust and Research Networks to engage with Industry. During 2024/2025 WSN had 14 active commercial studies. It is recognised that there is a huge potential in the Trust to increase commercial activity, therefore we have reached out to highly reputable commercial companies to put MWL on the international and national map. S&O site had 3 commercial studies on their portfolio. We have been reaching out to commercial partners and have submitted a number of expressions of interest with the aim of being chosen as a site, we hope that this will enable us to increase our commercial activity going into 2025/2026.

Table 8- Active Commercial Studies at WSN by Speciality 2024/2025:

Specialty	No. of Studies
Cardiovascular Disease	2
Children	2
Gastroenterology	4
Metabolic and Endocrine Disorders	1
Respiratory	2
Trauma and Emergency Care	1
Diabetes	1
Surgery	1
Total	**14***

* 1 Patient Identification Centre

Table 9 - Active Commercial Studies at S&O by Speciality 2024/2025:

Specialty	No. of Studies
Cardiovascular Disease	2
Diabetes	1
Total	**3***

*2 Patient Identification Centres

SECTION THREE: RESEARCH CONDUCT, GOVERNANCE AND FINANCE

3.1 The Trust is committed to the promotion of good research practice, ensuring that research is conducted according to appropriate ethical, legal and professional frameworks, obligations and standards. Research should be undertaken in accordance with commonly agreed standards of good practice. Good Clinical Practice (GCP) is a set of internationally recognised ethical and scientific quality requirements which must be observed for designing, conducting, recording and reporting clinical trials that involve the participation of humans. An understanding of GCP is a prerequisite for anyone carrying out, or involved in, clinical research and clinical trials. The RDI Department ensures that information and support is available to researchers, and that GCP training is made available to all staff involved in research. The RDI Department has a set of instructions which act as a guide to researchers and assists them in accessing and setting up NIHR online GCP training.

3.2 The RDI Manager is a GCP Facilitator, and helps to deliver courses across the North West Coast. Since COVID the majority of courses are delivered online or via TEAMS.

3.3 The 19 principles in the UK Policy Framework for Health and Social Care Research (2017) serve as a benchmark for the conduct of research. Adhering to these standards is a must and ensures the health and safety of research staff and participants.

3.4 The RDI Department has a suite of Standard Operating Procedures (SOPs). The SOPs cover all aspects of the set up and conduct of a research project. Joint SOPs were implemented in July 2024 to allow consistency across WSN and S&O.

3.5 In order to maintain the highest standards of rigour and integrity at all times, Principal Investigators are expected to sign an Investigator Declaration form prior to commencing any new research study. The declaration form very clearly outlines the Investigators' responsibilities when undertaking research at MWL.

3.6 An audit of Compliance with Good Clinical Practice re Consent, Record Keeping and Storage of Documents was undertaken at WSN. N100 research cases were included in the audit. The consent forms and patient information leaflets were present in 100% of cases. A completed Research Consent Process checklist was scanned in the casenotes in 99% of cases, which is an improvement of 11% since the previous audit (88%). A delegation log was present in 100% (n10) of study site files. The results from the S&O audit were similar.

3.7 It is good practice for the PI to be involved with, or at least be aware of all aspects of, the research study, particularly regarding Clinical Trials of an Investigational Medicinal Product (CTIMP). The Research Nurses from WSN meet regularly with the PI to complete a review, which is documented in a specific form, which demonstrates PI oversight of the study.

3.8 Anyone connected with research which involves NHS patients, samples, information, facilities, staff or services is expected to conduct research to the appropriate standards. This includes staff with letters of access, students and part-time staff, or those on short term attachments. The RDI Department works with Human Resources department to ensure that the correct employment checks are in place prior to issuing research approval.

3.9 The RDI Department is accountable through its Medical Director to the Trust Board sequentially through the Research Development and Innovation Group (RDIG), Clinical Effectiveness Committee and the Quality & Safety Committee. The RDIG meet quarterly; membership includes key local research stakeholders to ensure the Trust meets strategic objectives in relation to Research Development & Innovation. Members are selected for their specific role or because they are a representative of a professional group/speciality/directorate or division. In 2024 research was added to the agendas of the 4 Trust Divisional Clinical Quality and Governance Groups (Women's & Children, Medicine and Urgent Care, Surgical Care and Clinical Support and Community Services).

3.10 The Research Development and Innovation Group promotes, oversees and fosters clinical Research Development and Innovation within MWL Trust. The RDI Group meets quarterly and is chaired by Dr Ascanio Tridente, Clinical Director for Research.

3.11 The Research Practitioner Group (RPG) at MWL meet twice a year and plays an important role in the delivery of good quality research at MWL. NIHR recruitment is a standing item on the agenda, and updates on performance are discussed and plans put in place to achieve compliance.

3.12 The NIHR Clinical Research Network is responsible for the provision of the NHS Support resources to enable studies to be conducted in the local NHS regions they are responsible for. Within many Trusts this funding covers a number of different areas as follows:

- Research Nurses - feasibility support, and to recruit and manage patients in research studies.
- Non clinical research support staff – administrative staff who assist with study feasibility along with record keeping and data collection as part of research studies.
- Service Support departments – Pharmacy, Radiology and Pathology (where this service is provided by organisations as an NHS support activity in the delivery of clinical research).

3.13 Funding is allocated from the RDN NWC to support the RDI Department and Support Services. The total budget allocated to MWL in 2024/2025 was:

Table 10 – NIHR Funding allocation 2024/2025:

Funding	Amount
Delivery Budget	£827,928.00
Contingency Funding	£50.867.00
SRG Leads	£13.575.00
Life Sciences Funding	£55.000.00
Strategic Funding	£18.314.50
Commercial Incentive Funding	£15.000.00
Infrastructure Hub Funding	£42.072.00
Clinical Support Services Funding	£62.600.00
Overheads	£23.959.00
Marshalls Cross	£1,000.00
Total	£1.110,315.50

3.14 All Trusts were encouraged by the NIHR to produce an Income Distribution Plan. This provides a transparent and consistent approach to the distribution of income from commercial research studies. Commercial research is defined as research that is sponsored and funded by commercial companies, usually pharmaceutical or device manufacturers, and is directed towards product licensing and commercial development. It is a key strategic goal within the Trust RDI Strategy to increase commercial research contracts. This will only be achieved if clinicians are supported to do this research and are incentivised to do so in the form of income generation for their teams and departments. The money generated from commercially-sponsored studies is a valuable source of income for NHS Trusts. This income can be used to encourage key stakeholders to develop capacity for new research within the Trust and increase the volume, and therefore future income generation.

The principles of commercial income distribution are:

- Departments and individuals are recognised for their contribution to commercial research within the Trust and are incentivised fairly
- All costs incurred by the Trust are fully recovered
- Commercial research continues to afford both investigators and the Trust the opportunity to fund additional research related activities.

3.15 The RDI Department also supports smaller studies, including individual research undertaken as part of higher qualifications, e.g. PhD. This involves guidance through the RDI approval process and ethics review, and the provision of advice and training. As part of their continuing professional development, many staff aim to progress through higher qualifications and/or research work.

SECTION FOUR: KEY ACHIEVEMENTS

The following are examples of how MWL continuously drives to improve the quality of service provided through research:

4.1 As mentioned previously we are extremely proud to have recruited 2046 patients to research studies since the 1st April 2024. This is the result of a huge effort from all the staff within the RDI Department; it also demonstrates our commitment to offering patients and public the opportunity to take part in research.

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

Table 11 – Top Recruiting studies at MWL during 2024/2025

STUDY	SPECIALITY	
UK Genetic Prostate Cancer Study	Cancer	NWC
Oxford Cognitive Screen - Visual Impairment adaptation	Ophthalmology	Top in UK
RASPER (joint top recruiter)	Respiratory	NWC
Visual scanning training for hemianopia (SEARCH)	Ophthalmology	Top in UK
Statins for Improving Organ Outcome in Transplantation (SIGNET)	Critical Care	NWC
iGBS3	Children/ Obstetrics	Top in UK
Melanoma Wide Excision Trial - MelMarT-II	Cancer	Top in UK
IBD Bioresource	Gastroenterology	NWC
Molecular Genetics of Adverse Drug Reactions (MOLGEN)	Genetics	Top in UK

4.3 In 2024/2025, 84% (n19) of research studies at WSN met the recruitment target within the specified timeframe "Recruiting to Time and Target" (RTT). The number of studies that met the RTT target at S&O was 89% (n9)

We also met the following NIHR CRN NWC high level objectives:

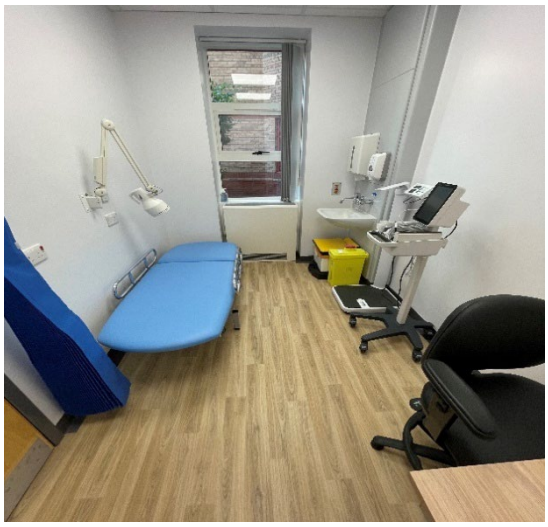
Percentage of open to recruitment commercial contract studies that were predicted to achieve their recruitment target – WSN 50% (n2)

Percentage of open to recruitment non-commercial contract studies that were predicted to achieve their recruitment target – WSN 85% (n34)

Percentage of open to recruitment non- commercial studies for former S&O predicted to achieve their target – S&O 84% (n27)

4.4 This year we have received some positive comments from Sponsors regarding our study set times. We strive to keep the study set up times to an average of 21 days, issuing capacity and capability (C&C within 21 days of receipt of the local information pack. This makes us attractive to commercial sponsors who place this high on their priorities when selecting hospitals to take part in their research.

4.5 In 2024, MWL opened two new Research Hubs at Ormskirk Hospital and Marshalls Cross GP Surgery. They have also expanded the existing Research Hub based at Whiston Hospital. This was using the National Institute for Health & Social Care Infrastructure funding that we secured at the end of 2023.These facilities offer patients a safe, comfortable and friendly environment to take part in essential research and will be vital to the delivery of research at the Trust.



Launch of the new Research Hub at Ormskirk Hospital, May 2024

Opening of the expanded Research Hub at Whiston Hospital in September 2024

The Primary Care Research Hub at Marshalls Cross GP surgery was officially opened by Chief Executive Ann Marr and will play a crucial role in enhancing research engagement and capacity within the organisation

4.6 Examples of feedback from patients who have been seen in our Research Hubs:

The team at Whiston Hospital welcomed their first patient into the bright and spacious clinic. Michael Harrison, who is taking part in a study for a new treatment which aims to reduce blood pressure for patients living with uncontrolled hypertension, explained how it has impacted his life. He said: "*The condition really affects my daily life and has done for over 10 years now. I recently had an operation which had to be postponed due to my high blood pressure, but I managed to get it down to a safe level, where I could finally have surgery*."

Quote from a patient taking part in the Euroaspire/Aspire-to-Action study:

"It has been a pleasure to be able to take part in this trial, I feel like I am making a difference to future care. The Research Hub is a great space. The research nurses plan my appointments so that everything goes smoothly with no delays. The care has been fantastic. All the staff are friendly and welcoming"

4.7 MWL were notified in January that they had two posters accepted by the Research & Development Forum to be displayed at their annual conference in May 2025. One is relating to the opening of the research hubs and building capacity, and the second poster is relating to working differently by offering evening clinics to make appointments more accessible for our patients. Having the Research Hub at the Ormskirk site has allowed the research team to put on evening clinics for our research participants. This is makes it easier for our patients who are working or have other commitments that make it difficult for them to attend daytime clinics.

4.8 On the 22nd May 2024 the Research Team from Whiston Hospital recruited to an important study, the FUSE study "Feasibility of Using resting heart rate and step-counts from patient-held Sensors during clinical assessment of medical Emergencies",

Recruitment to the study took place on one day and involved Research Nurses, Doctors, Nurses, and Research Practitioners, along with administrative support staff.

The study was led by the Principal Investigator, Dr Magda Nasher, who worked hard to engage as many staff as possible. This was a great success and demonstrated how staff from across the trust worked collaboratively to offer our patients the opportunity to take part in a study that might aid a better estimate of their severity of illness and help clinicians to better understand and interpret any changes or trends in their condition.

4.9 In March 2025 we took part in the Understanding escalation area and corridor care in UK emergency departments (UNCORKED) study. The study aims to estimate the proportion of UK emergency department patients experiencing escalation and corridor care, establish which patients experience such care, and devise a standard definition for escalation area and corridor care. In total at MWL we collected data from 647 patients over a 2-week period and 5 snapshots in time and were one of the top recruiting Trusts in the UK (out of 150 Trusts) . The Principal Investigators were Dr Craig Rimmer from the S&O site and Dr Robert Fuller from the WSN site. The study was also supported by or Research Team and several Resident Doctors whose input was invaluable to the success of the study.

4.10 We are proud to have recruited the 1st UK patient to the Gentafoil study at Whiston Hospital - A Post approval study to evaluate the safety and efficacy of Gentafoil resorb for the prevention of tissue adhesions.

Our Principal Investigator Mr Stephen Lipscombe said:

"It has been a pleasure working alongside the Orthopaedic and Plastic Surgery Departments at Whiston to recruit the first patient in the UK to the Gentafoil study. The study will evaluate the effectiveness of Gentafoil at reducing adhesions following hand surgery, improving finger movement and function. The support of the research department has been paramount to this success"

4.11 The Whiston site took part in two important commercial Baxdrostat Resistant Hypertension studies. Although recruitment to the study was difficult the team received positive feedback from the sponsors for all their efforts and hard work in screening for the patients.

Dr Andrew Hill, Principal Investigator for the studies said:

'Stroke is the leading cause of disability and third commonest cause of death in the UK. Most strokes can be prevented by treating high blood pressure throughout life, identifying and treating atrial fibrillation and managing cholesterol. For a small number of people with difficult to treat high blood pressure which does not respond to current treatment options, it is important as healthcare professionals to do our part to find new treatments to help reduce the risk of stroke, heart disease and kidney disease as much as we can. We now have three patients on two arms of a study looking at a new drug for managing blood pressure where existing medication has not achieved satisfactory control. MWL has an amazing team of research-interested people looking at stroke care, and it is fantastic to be able to work with our patients to try and push the boundaries of different aspects of stroke care.'

4.12 MWL took part in a study called "BLING 3". The purpose of the study was to determine whether seriously ill adults with severe infection who receive a beta-lactam antibiotic via continuous IV infusion compared with intermittent IV infusion (for 30 minutes every 6 or 8 or 12 hours) had improved outcome 90 days later. The results of this study were published in *Intensive Care Medicine. 51(1), pp.230-231. [Online]* Mr Greg Barton, Clinical Pharmacist, at MWL informed us that study enrolled 7,000 patients worldwide, 3,000 of these patients in the UK. The UK had 55 sites and MWL were the 6th highest recruiter with 113 patients. The results of this paper will change practice which is good news for those working in critical care. He said that without the support of our dedicated Research Nurse, who works on Critical cares studies, this fantastic achievement would not have been possible.

4.13 Cancer Research at MWL

The sustained efforts of the cancer research team have allowed patients at MWL to access cancer studies.

From the individual cancer patient and public health perspectives, taking part in high quality cancer research studies allows cancer patients the opportunity to benefit from access to new treatments and the opportunity to help researchers find better treatments for other cancer patients in the future. The cancer research team are there with the patients and their families from the beginning at diagnosis, through their treatment, living with their diagnosis and beyond. Being part of a cancer research study is seen as part of the patient's pathway and receiving excellent patient care whilst being able to contribute to the best future care for all.

The team are proud to be second highest recruiter in the UK to the MelMarT II study. This is an international Multi-centre Randomised Control Trial, Investigating 1cm v 2cm Wide Excision Margins for Primary Cutaneous Melanoma.

Overall, the team have recruited to the following tumour groups:

Table 12 – Cancer Tumour Groups/number of recruits:

Breast	35	Lung	24
Colorectal	2	Skin	55
Gynae	1	Upper GI	0
Haem	4	Urology	8
		Total	**129**

The Cancer Research team is still the only research team to be Macmillan adopted. This is an exceptional achievement and demonstrates our commitment to delivering the best support and treatment for our cancer patients.

MWL took part in the Mammo- 50 study, The Mammo-50 study was carried out to try to find the safest and most effective follow up for women after breast cancer surgery. The findings were published in Lancet 2025; 405: 396–407. The study concluded that the women who had less frequent mammograms were no worse off than the women having yearly mammograms. Having fewer mammograms can mean less inconvenience for women and reduced stress which can often be caused by waiting for results. Offering less frequent mammograms could also reduce costs and workload to the NHS.

We received a Quality-of-Life questionnaire from one of the patients being treated at St Helens Hospital, where they commented very positively regarding the treatment and care they had received, stating it had been “extremely good”.

In 2024/2025 the Cheshire and Merseyside Cancer Alliance Data and Analytics team put together a Cancer Research Activity dashboard which contains all the NIHR portfolio research data for Cancer across the North West. This is an excellent tool that allows us to track our cancer research activity.

4.14 Other areas across the Trust are research active and committed to conducting research, i.e. Cardiology, Dermatology, Diabetes, Intensive Care, Ophthalmology, Paediatrics, Obstetics and Gynecology, Rheumatology Without the continued support of the doctors and nurses involved we would not be in the position to offer our patients the opportunity to take part in research. A full list of all the active studies being undertaken at MWL during 2024/2025 can be found in Appendix 1.

4.15 Both the WSN and S&O sites took part in the BronchStart study (Covid impact on RSV Emergency Presentations). The aim of the study is to report the timing, frequency and clinical severity of RSV infection in children under two years of age presenting to paediatric hospitals in the UK and Ireland. Due to a huge effort by our Paediatric Research Nurse, who worked across both sites, we supported the study by collecting 292 RSV samples.

4.16 MWL were pleased to have taken part in the Bronch Start study “Maternal views on RSV vaccination during the first season of implementation in England and Scotland” the findings of the study were published in the Lancet volume 25, Issue 3, E135-E136 March 2025. The study found generally positive views in mothers about the safety and importance of the maternal RSV vaccination.

4.17 Our commercial sponsors have provided us with some excellent feedback when conducting commercial research:

“On behalf of the study team I would like to extend our warmest congratulations to your dedicated study team for your 1st successful randomisation. This is truly remarkable. We are deeply grateful for the hard work and meticulous attention your team has demonstrated. It is through such diligence that we can make strides towards our goal”. (communication from the sponsors of a commercial hypertension study).

4.18 In November 2024 two Consultants at MWL were notified that they had been successful in securing Specialty Lead positions with the new North West Coast Regional Research Delivery Network (RRDN). Dr Ascanio Tridente has been appointed as the Specialty Lead for Critical Care, and Dr May Ng the Specialty Lead for Paediatrics. This is excellent news for the Trust, they will provide leadership, advice and support research delivery and they will also be a vital link between the regional, geographically based networks. Dr Ravish Katira, Consultant Cardiologist at Whiston Hospital, is also a Speciality Lead for Cardiovascular disease.

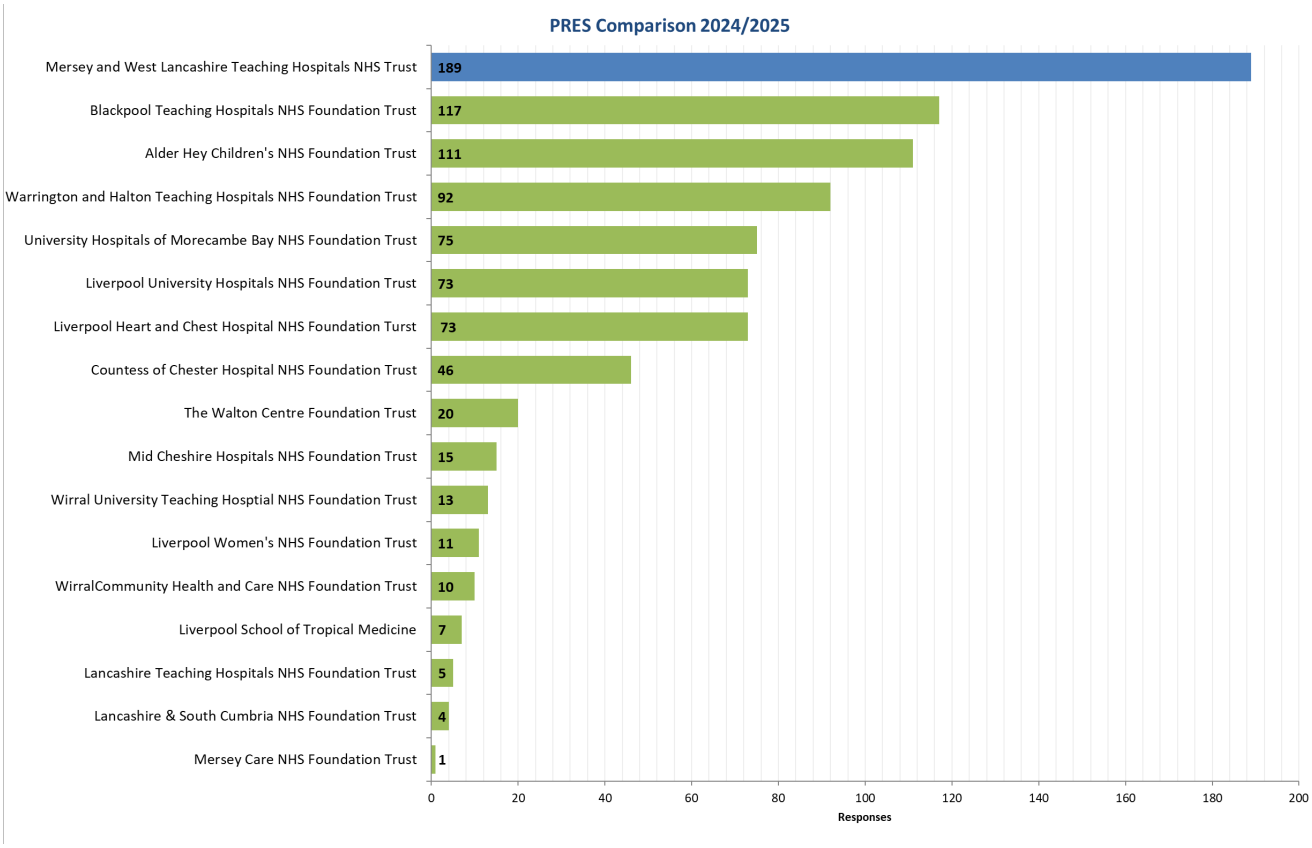
4.19 An exciting opportunity arose for MWL in 2024/2025, we were invited to work collaboratively with the Liverpool Clinical Research Unit (CRU). The CRU is a Phase 1 accredited unit. The unit undertakes and delivers clinical trials in patients and healthy volunteers with a particular emphasis on early phase research. We have successfully referred patients to the unit thus giving them the opportunity to take part in groundbreaking research that otherwise would have been unavailable to them.

4.20 We have continued to strengthen and support strong partnerships with our neighbouring Universities. These partnerships have allowed us to seek out the best academic expertise to work with our staff and patients wherever possible to ensure that our patients benefit from world-class research. In September 2024, MWL were invited to the inaugural Edge Hill University Health Research Institute Showcase event. This was an opportunity for students to share their research findings and be inspired by world-leading speakers and experts sharing cutting-edge insights shaping the future of health and social care.

4.21 Two of our research nurses are members of the Trust's Digitalisation Group. We are keen to ensure that our research staff are kept up to date with any new developments and have the opportunity to provide input that will result in more effective data sharing across the health and care system and digital transformation of care pathways.

4.22 The Participant in Research Experience Survey (PRES) is conducted annually by the National institute For Health Research (NIHR) Clinical Research Network (CRN). The PRES is a priority for MWL as participant experience is at the heart of research delivery by providing an opportunity for as many research participants as possible to share their experience of taking part in research. In 2024/2025 MWL received the most responses to the PRES across the North West Coast.

The Research Team introduced several methods for obtaining feedback and valued the patients' views on taking part in research, including face to face conversations, implementing QR code and sending out postal questions. Please see below how MWL compared to other Trusts across the region in obtaining patient feedback.



On the 6th June 2024 our Research team was recognised for their contribution to the Patient Research Experience Survey at the NIHR Research Extravaganza away day:

Some examples of the PRES responses include:

"All the staff involved in the study were very helpful & patient with me. Thank you"

"The nurse who contacted me and subsequently took my blood samples, as well as talking me through all the forms & filled in, was clear, informative and friendly. A thorough professional"

"Everything was explained clearly to me, the lady I spoke to was very professional"

"Thank you so much for calling me and asking me to be part of this trial, I am so happy its working 6 months ago I was miserable not knowing what to do next as nothing seemed to be working. Thank you so much". (patient taking part in an ulcerative colitis study)

"Thank you so much for everything and all the support you have given me throughout the clinical trial. This trial has given me my life back, I will be forever grateful" (patient taking part in an IBS study)

Feedback from the research participants can help us to understand both what they are doing well and where there are opportunities to improve. The PRES has already been instrumental in how we shape our services and feedback has led to the MWL expansion of research facilities at Whiston Hospital, with planned expansion at Southport Hospital.

4.23 MWL have continued to promote Research and Innovation to staff and patients via:

- Social media, regularly posting, good news stories on Facebook and Twitter
- Communications Team at MWL and the RRDN (formerly the CRN NWC)
- Library Services
- Training & Education
- Taking the Trust Quality Bus out to various departments throughout the Trust to promote research and highlight any studies that are taking place in their areas.
- Trust Brief Live

4.24 MWL produce a Research Newsletter which is published quarterly and highlights all the good work of the department and provides information/ updates for our staff.

4.25 Staff publications (research and academic) have been recorded by the library and knowledge services at MWL, which shows our commitment to transparency, and our desire to improve patient outcomes and experience across the NHS.

4.26 The Trust has recently signed up to the EDEPI Programme collaborating with LJMU. The EDEPI PhD programme has been created to enable NHS staff from racially minoritised groups to set a new research agenda relevant to their experiences. PhD study is not only a chance to undertake important research with the potential for real-world change, but an opportunity for unique professional development that can advance your career. Diversity in leadership is crucial for the future of the NHS, particularly in light of the need to implement the NHS Long-Term Plan, which promotes greater staff diversity at all levels, and expresses the need for transformational change across health services.

The Research workforce is central to our ability to meet the DOH and National Institute for Health Research (NIHR) objectives whilst continuing to provide high quality care and offering patients the opportunity to take part in research. It is due to all the highly skilled and dedicated staff that we have been able to produce such positive results in this year's annual report.

SECTION FIVE: EDUCATION AND TRAINING

5.1 It is a legal requirement that all staff involved in clinical trials complete Good Clinical Practice (GCP) training, and the Trust has facilitated this for staff by signposting them to the online course. Commercial companies also regularly run refresher GCP courses for staff involved in the clinical trials.

5.2 The RDI Manager at WSN is a Good Clinical Practice Facilitator and facilitates these courses across the North West Coast Clinical Research Network. Our RDI Manager at the S&O site has applied and been successful in her application to become Facilitator for the GCP Consolidation sessions and PI Training she will complete the training in June 2025.

5.3 The NIHR offer career development opportunities, including training programmes and fellowships based in the NIHR research infrastructure. Training and career development awards are available at different levels and accessible by different professional backgrounds. These awards are all managed by the NIHR Trainees Coordinating Centre and comprise both personal awards, which can be applied for directly, and institutional awards, which should be applied for through the host institution. They also develop and support the people who conduct and contribute to the NIHR CRN Portfolio of studies. This is done by providing training opportunities via the NIHR Learning Management System, which includes a variety of online and taught courses. The RDI Department also signpost staff to these resources and participation.

5.4 The NIHR introduced an Associate Principal Investigator (PI) Scheme which aims to develop junior doctors, nurses and allied health professionals to become the PIs of the future and provides formal recognition of a trainee's engagement in NIHR portfolio research. The Trust is committed to developing future PIs, therefore we have engaged with this initiative.

5.5 Gemma Lewis (Clinical Research Fellow- Diabetes) is working on a PhD project in partnership with Liverpool University. The DIABETES-PRO study is a feasibility study evaluating the impact of differing completion rates of a face-to-face diabetes self-management education programme (DSME) on patient reported outcome measures (PROMs) in type 2 diabetes. The study has been a huge success; 709 individuals screened with 138 consenting to participate. Of the 138 eligible, 120 were randomised between May 2024 and February 2025 (30 per group). Participants were generally middle-aged [mean age 61 years], with an average HbA1c of 68mmols/mol, had a diabetes duration of 8 years and represented some of the poorest deprivation deciles in the United Kingdom [mean IMD 3.0]. Randomisation, outcome assessments, education intervention and

use of medical records were feasible and acceptable to patients with a 94% completion rate. Interim analysis suggests that there is a significant difference between PROMs when considering differing completion rates of DSME, with only 100% completion meeting the minimally clinical important difference across all measures.

5.6 Research Support Service (RSS) - The RSS provides expert support and advice to applied health, public health and social care researchers on the design and delivery of research and the development of research funding applications.

5.7 There was evidence that all staff had annual PDRs and appraisals, and evidence that staff had the opportunity to set objectives.

5.8 All of the RDI Department staff were issued with the research SOPs. They were asked to sign the training and reading log declaring that they had read and understood all of the SOPs.

5.9 RDI Department staff also attended various training sessions, seminars, to maintain knowledge and expertise in order to provide a good service, with appropriate advice and signposting to researchers, as well as ensuring quality data management and timely returns of performance data to the CRN, DOH and Trust Board as required.

SECTION SIX: LINKS WITH OTHER GROUPS / PARTNERS

6.1 The Trust has links with key external stakeholders such as the RRDN NW who provide funding from the National Institute of Health Research (NIHR), the research arm of the Department of Health. Regular business planning meetings with the Delivery Managers enable us to scope the NIHR portfolio and identify any potential new studies.

6.2 We are in a unique position at MWL to have the Marshalls Cross GP surgery based at our St Helens Hospital. We have continued to work with them and are still providing finance and study support. Our Research Nurses now have access to the GP EMIS system at Marshalls Cross surgery which allows them to run searches for eligible patients for recruitment into NIHR portfolio studies. Targeted searches have drastically cut down the amount of time that nurses spend on feasibility and ensures that we are not taking on studies that we are unable to recruit to. The practice has recruited to four NIHR portfolio studies during 2023/2024:

Table 13 – Marshalls Cross GP Surgery recruiting studies during 2024/2025

Study Title	
Skills for Adolescent WELLbeing (SWELL), version 1:	A Randomised Controlled Trial of a group CBT intervention for young people with parental depression treatment optimisation
Chronology in multimorbidity clustering and its effect on treatment burden and the utilisation of health and social care services	The experiences of multimorbidity patients regarding treatment burden
ThinkCancer Phase III RCT	A randomised controlled phase III trial of a novel behavioural intervention for primary care teams to promote the earlier diagnosis of cancer

6.3 Commercial Research Delivery Centre (CDRC). In 2024 The Department of Health and Social Care (DHSC) announced plans to establish 20 Commercial Research Delivery Centres (CRDCs), giving patients access to pioneering clinical trials and treatments in record time. The new centres will enhance the speed and efficiency of commercial clinical research delivery, contributing to the health and wealth of the nation. They will work with industry and other research delivery infrastructure to support the UK's status as one of the best places in the world for innovative companies to bring their portfolio of research. (NIHR).
The host for the new NIHR Commercial Research Delivery Centre (CRDC) is NHS University Hospitals of Liverpool Group (UHLG), formerly known as Liverpool University Hospitals. In 2024 MWL were notified that they had been successful in a bid to become one of its 10 spoke organisations.

The new, purpose-built research facilities will enable "Efficient delivery of research studies and a smooth, pleasant and safe experience for study participants".

Dr Peter Williams. The Trust's Medical Director, said:

"We're delighted to be part of this important regional initiative because it will offer even more opportunities for our local population to take advantage of new treatments and healthcare technologies."

Dr Ascanio Tridente, the Trust's Clinical Director of RDI (WSN site) and new NIHR Regional Research Delivery Network specialty Lead for Critical Care, said:

"We are looking forward to expanding our collaboration with all regional and national research partners through the establishment of the new NIHR Commercial Research Delivery Centre, which will provide the Trust's patients with more opportunities to be part of research and to benefit from new treatments"

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

6.4 The Trust has links with LHP (Liverpool Health Partners). The LHP R&D Directors Group is attended by the Chair of the MWL Research Development and Innovation Group. In December 2023 MWL also became a member of the Applied Research Collaboration, North West Coast (ARC), which aims to work in collaboration by bringing together academics, health and social care providers, members of the public, universities, and local authorities to improve the quality, delivery and efficiency of health and care services reduce health inequalities and increase the sustainability of the health and care system both locally and nationally. Dr Ascanio Tridente is the main link for this collaboration from MWL.

6.5 We have continued to strengthen partnerships with local academic organisations, including Manchester Metropolitan, Edge Hill, and Liverpool Universities. Professor Greg Irving (Health Research Institute and Director of the Edge Hill Primary and Integrated Care), attended our Research team meeting to discuss how we can work together with academic and Trust researchers to produce good quality research that will benefit our patients in the future.

6.6 We have worked with the phase 1 clinical trial centre based in the Liverpool University Hospital NHS Foundation Trust. This collaboration has allowed us to refer to them and give them an opportunity to take part in early phase studies and have access to the newest and most innovative treatments.

6.7 Our links with Clatterbridge Cancer Centre and our Cancer team at WSN were established and processes put in place to facilitate working together on certain cancer studies. However there has been little activity in 2024/2025.

6.8 We have developed partnerships with other local academic organisations, including Manchester Metropolitan University (MMU), Edge Hill and Liverpool Universities. Our RDI Clinical Director, Dr Ascanio Tridente, is working on various research projects with MMU. During 2024/2025 he was awarded an Honorary Professorship from Edge Hill University, he will continue to work with the University to explore collaborative projects and funding opportunities.

6.9 The Trust is a partner in the Innovation Agency Northwest Coast Academic Health Science Network (NWC AHSN) which aims to:

- Transform and improve patient outcomes
- Improve quality and productivity
- Drive economic growth and wealth creation

6.10 RDI is linked with the Quality Improvement and Clinical Audit Department as part of the Trust governance requirements.

6.11 The RDI Managers are members of the Research and Development Managers' Group. The purposes of the meetings are to share best practice, provide peer to peer support and to keep up to date with current development in the R&D community.

6.12 The RDI Department now has links with Library and Knowledge Service and has a specific section on their website where staff can now access information about research services and resources. The Research X and Facebook accounts are now well established.

SECTION SEVEN: INNOVATION AT WSN

7.1 All members of staff are encouraged to solve clinical and service problems and to develop new ways of working which benefit patients and improve their care. Many innovations will not be patentable or copyrightable, but nevertheless have enormous potential benefits if successfully implemented. At MWL we are keen to provide staff with opportunities to pursue their ideas. Therefore, the Trust's RDI Department has responsibility for disseminating information on Intellectual Property (IP) rights, promoting awareness of those rights across the Trust, and offering advice as required to ensure activities are managed appropriately. The IP policy sets out the rules of ownership, protection and exploitation of IP arising from an employee's work. It aims to maintain a balance between the legitimate needs of the Trust to protect its interests and the provision of a creative, innovative working.

7.2 We received several enquires that have required the services of our independent IP Advisor. However, none of these have yet gone onto the development stage.

7.3 UK Research and Innovation works in partnership with universities, research organisations, businesses, charities, and government to create the best possible environment for research and innovation to flourish. We are working collectively with universities to submit grant applications to enable individuals and groups to pursue world-class research and innovation.

SECTION EIGHT: CONCLUSIONS

8.1 In conclusion, 2024/2025 has been another successful year for MWL. We are now well established with the merger of the two Trusts and are seeing some positive feedback from both patients and sponsor organisations. Our team's dedication to enhancing the research participants journey is evident. We know that providing a comfortable, secure environment for patients is important in making their research journey a pleasant experience. The new Research Hubs have made a huge difference to both patients and staff, and it is fantastic to see research flourishing at MWL.

8.2 Recruitment to research studies during 2024/2025 has also been excellent, being in 8th position on the new Research Delivery Network dashboard shows that we are holding our own against some of the larger organisations across Manchester and North West.

8.3 Once again we were top of the NIHR Patient Research Experience Survey dashboard by some distance. Patient feedback is crucial to us, it helps us to understand if any improvements in our service are required. It was pleasing to note that most of the feedback was positive, knowing that our patients are having the best experience is something that we are very proud of.

8.4 During 2024/2025 MWL were top recruiters in a number of specialties across the RRDN. This demonstrates our commitment and hard work to ensure our patients are offered the opportunity to take part in cutting edge research.

8.5 Our performance with regards to meeting the predicted recruitment to time and target for non-commercial studies was over 80% , and 50% for our commercial studies.

8.6 We recruited the first UK patient to the commercial "Gentafoil study". Our team worked hard with the sponsors of this study and had input into the design of the protocol, they have also provided important feedback during the study recruitment phase.

8.7 MWL have contributed to several published studies that have made a difference to or changed practice to the way in which care is delivered to patients.

8.8 Our cancer team have been extremely busy, 129 patients with cancer took part in cancer research. This is in addition to those who are in long term follow up and remain on their study schedule. The team has worked consistently hard to ensure that clinical trials are embedded in the MDT meetings as part of the decision making around patient treatment options. All of this benefits our patients and allows them access to the latest cancer treatments.

8.9 There was a slight decrease in the number of sponsored studies during 2024/2025, 7 studies were sponsored by MWL compared to 9 in the previous year. The Sponsor of a research study is the organisation or partnership that takes on overall responsibility for proportionate, effective arrangements being in place to set up, run and report a research project. At MWL this is something that we review carefully before agreeing to act as the sponsor for the study.

8.10 The NIHR RDN delivery budget for MWL increased from £756.208.00 in 2023/2024 to £827,928.00 in 2024/2025. Although this is a slight increase from the previous year the funding from the NIHR RDN doesn't take into account the incremental pay rises or any cost-of-living rises, therefore the funding envelope doesn't allow for growth. The solution to this is to increase the amount of commercial research that we conduct which will allow us to generate more income to reinvest back into the RDI department and promote growth.

8.11 In 2024 MWL were notified that we had been successful in a bid to become one of its 10 spoke organisations of the newly formed NIHR Commercial Research Delivery Centre (CRDC). We have started working with the

NHS University Hospitals of Liverpool Group (UHLG) who are in the process of setting up the systems and processes required to run the CRDC.

8.12 Partnerships with Edge Hill, Manchester Metropolitan Universities and Liverpool Universities continued to strengthen during 2024/2025.

8.13 It is encouraging to see how MWL have collaborated with neighbouring organisaitons such as the Liverpool Phase 1 Clinical Research Unit (CRU). This has allowed our patients to have access to early phase trials that can only be delivered by the CRU. It also gives them an opportunity to take part in life saving research that could help patients who have exhausted all other options.

8.14 We have provided finance and study support to Marshalls Cross GP surgery with the aim of encouraging and expanding research at the practice.

SECTION NINE: RECOMMENDATIONS FOR 2025/2026

Our aims for 2025-2026:

9.1 In line with the Governments 10-year plan, we aim to increase the amount of commercial research that we undertake at MWL. However, it is also important to ensure that our performance, with rapid study set up and delivery, remains within the specified timelines. This is essential to ensure success in increasing the commercial portfolio.

In April 2025 the Prime Minister announced action to accelerate the discovery of life-saving drugs, improve patient care and make Britain the best place in the world for medical research. The government and the Wellcome Trust will invest up to £600 million to create a new health data research service. This will transform the access to NHS data by providing a secure single access point to national-scale data sets, slashing red tape for researchers.

Clinical trials will also be fast-tracked to accelerate the development of the medicines and therapies of the future, with the current time it takes to get a clinical trial set up cut to 150 days by March 2026 - where latest data collected in 2022 was over 250 days.

In addition the government announced the creation of a new UK-wide Health Data Research Service. The new service will create a secure single access point for national data and transform the health data ecosystem in the UK[12].

The Research Delivery Networks will be moving towards measuring success in real time. This is particularly important in clinical trials, where benchmarks and key performance indicators like recruitment times are monitored.

MWL will keep abreast of these developments and adapt systems and processes accordingly. RDI will ensure that staff are kept informed and updated of any changes.

9.2 In order for us to set up studies quickly, and recruit to time and target it is essential that we carry out robust feasibility. Ensuring that we have the correct population and the capacity and capability to deliver the studies at an early stage is vital to the successful delivery of the study. We will monitor our performance closely to ensure that we are on track with the recruitment and study timelines.

9.3 The money generated from commercial research will be reinvested to develop capacity/resources for research within the Trust.

9.4 RDI will endeavour to strengthen collaboration with Higher Education Institutions, fostering a culture of research and innovation, seeking grants funding and providing opportunities for education, in collaboration with the local Universities.

9.5 We aim to increase research participation at our Marshalls Cross GP practice. With the support of RRDN funding we plan to recruit a research nurse who will be responsible for identifying and recruiting patients to primary care studies.

9.6 We intend to increase patient recruitment into NIHR adopted clinical trials.

9.7 Continue to explore research options in specialities which are not research active.

9.8 Maintain and expand robust procedures to initiate, deliver and manage research, thus increasing opportunities for patients to participate in high quality clinical research.

9.9 Engage and communicate with patients and service users. We will ensure that the NIHR Patient Research Experience Survey is embedded into the patients' research journey. We will also feedback both positive and negative experiences, so that we can put action plans in place if necessary.

9.10 Continue to update our social media and website platforms to help promote research. In addition to this we will explore new ways of promoting research to ensure that we are visible as a Research Active Trust.

References:

1. Health and Social Care Act, 2012
   https://www.legislation.gov.uk/ukpga/2012/7/section/23/enacted

2. Embedding Research in the NHS
   https://www.england.nhs.uk/aac/what-we-do/embedding-research-in-the-nhs/

3. Health Research Authority
   https://www.hra.nhs.uk/about-us/news-updates/blog-review-2024-and-look-ahead-next-year/

4. Managing Research Finance in the NHS
   https://www.england.nhs.uk/long-read/managing-research-finance-in-the-nhs/Office for Life Sciences -

5. Research Delivery Networks
   https://www.nihr.ac.uk/support-and-services/support-for-delivering-research/research-delivery-network

6. Commercial Research Delivery Centres
   https://www.gov.uk/government/news/100-million-public-private-health-research-boost#:~:text=%C2%A3100%20million%20public%2Dprivate%20health%20research%20boost%20*,to%20benefit%20from%20the%20latest%20innovative%20treatments

7. New Clinical Trials Regulations
   https://www.hra.nhs.uk/about-us/news-updates/new-uk-clinical-trials-regulations-signed-into-law-implementation-period-begins/

8. Research and innovation to drive future outcomes improvement
   https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/research-and-innovation-to-drive-future-outcomes-improvement/#ref

9. The Association of Medical Research Charities
   https://www.hra.nhs.uk/about-us/news-updates/amrc-briefing-paper-embedding-research-nhs/#:~:text=On%2019%20September%202024%20the,deliver%20research%20throughout%20the%20NHS.

10. Health Research Authority
    https://www.hra.nhs.uk/about-us/what-we-do/our-strategy/

11. Health Innovation Agency North West
    https://www.healthinnovationnwc.nhs.uk/

12. Prime Minister turbocharges medical research
    Prime Minister turbocharges medical research - GOV.UK

APPENDIX 1 - List of Research Studies with recruitment 24/25

Study Short Title	NIHR Managing Specialty	Site Name	Recruitment 2024-2025
A post approval study to evaluate the safety and efficacy of Gentafoil	Surgery	WSN	14
AIP	Diabetes, Metabolic and Endocrine	WSN	10
AIRWAYS-3	Critical Care	WSN	3
ALLHEAL	Gastroenterology and Hepatology	S&O	69
ALLHEAL	Gastroenterology and Hepatology	WSN	21
ANTHEM-UC	Gastroenterology	WSN	1
ATNEC	Cancer	WSN	6
BADBIR	Dermatology	S&O	3
BADBIR	Dermatology	WSN	1
Bax24 Ambulatory Blood Pressure Monitoring Study	Cardiovascular	WSN	1
Baxdrostat Resistant Hypertension Study	Cardiovascular	WSN	1
Biomarkers and Stratification To Optimise outcomes in Psoriasis (BSTOP)	Dermatology	S&O	4
BSR-PsA	Musculoskeletal and Orthopaedics	WSN	6
BSR-PsA	Musculoskeletal and Orthopaedics	S&O	3
Covid impact on RSV Emergency Presentations: BronchStart	Children	WSN	175
Covid impact on RSV Emergency Presentations: BronchStart	Children	S&O	117
CP357 - Biatain Fiber Ag on burns	Trauma and Emergency Care	WSN	1
EUROASPIRE VI/ASPIRE-TO-ACTION	Cardiovascular	WSN	19
Fluids Exclusively Enteral from Day 1 (FEED1)	Children	WSN	1
FUSE	Trauma and Emergency Care	WSN	19
GCA Consortium	Musculoskeletal and Orthopaedics	WSN	1
GEKO Venous Thromboembolism Prevention Study	Stroke	WSN	7
GenOMICC	Critical Care	S&O	19
Giant PANDA	Reproductive Health and Childbirth	S&O	1
Huawei Stroke Study	Stroke	WSN	13
HYST	General Practice	WSN	9
IBD Bioresource	Gastroenterology and Hepatology	WSN	114

Study Short Title	NIHR Managing Specialty	Site Name	Recruitment 2024-2025
IBD Bioresource	Gastroenterology and Hepatology	S&O	32
iGBS3	Children	WSN	280
IMID BioResource	Musculoskeletal and Orthopaedics	WSN	57
IMID BioResource	Musculoskeletal and Orthopaedics	S&O	24
Improving Wrist Injury Pathways (I-WIP): a qualitative study	Musculoskeletal and Orthopaedics	WSN	2
iRehab	Critical Care	WSN	1
Melanoma Wide Excision Trial - MelMarT-II	Cancer	WSN	31
Metoclopramide for Avoiding Pneumonia after Stroke (MAPS-2) Trial	Stroke	WSN	5
Molecular Genetics of Adverse Drug Reactions (MOLGEN)	Gastroenterology and Hepatology	WSN	65
MOSAICC	Critical Care	WSN	2
mRCT of SELF-BREATHE for Chronic Breathlessness	Respiratory	S&O	23
NAFLD BioResource	Gastroenterology and Hepatology	WSN	6
NAFLD BioResource	Gastroenterology and Hepatology	S&O	5
Neonatal nursing retention	Children	S&O	6
Neonatal nursing retention	Children	WSN	1
ODD SOCKS	Trauma and Emergency Care	WSN	1
OPACE	Respiratory	WSN	1
Oxford Cognitive Screen - Visual Impairment adaptation	Stroke	WSN	11
Oxford Cognitive Screen - Visual Impairment adaptation	Stroke	S&O	6
PERISCOPE	Musculoskeletal and Orthopaedics	S&O	3
PLUMB	Respiratory	WSN	17
RADAR (UK-MRA Myeloma XV)	Cancer	WSN	4
RAPID	Respiratory	WSN	2
RASPER	Respiratory	WSN	5
RECOVERY trial	Infection	WSN	5
Reducing medication-related harm (MRH) in older people (PRIME-3 Study)	Ageing	S&O	1
RESPOND WP4	Surgery	WSN	12
RESULT Hip Version 1	Anaesthesia, Perioperative Medicine and Pain Management	S&O	4
Self-management in patients with adrenal insufficiency	Metabolic and Endocrine Disorders	WSN	8

Study Short Title	NIHR Managing Specialty	Site Name	Recruitment 2024-2025
SPIROMAC	Children	S&O	7
SPIROMAC	Children	WSN	6
The I-DSD Registry	Diabetes, Metabolic and Endocrine	WSN	1
The ROSETA Optimisation Trial	Cancer	WSN	23
The Tommy's National Rainbow Clinic Study	Reproductive Health and Childbirth	S&O	6
Toxicity from biologic therapy (BSRBR)	Musculoskeletal and Orthopaedics	WSN	28
Tozorakimab in patients hospitalized for pneumonia with hypoxemia at risk of respiratory failure	Respiratory	WSN	1
TRACS Liverpool Part 2	Infection	WSN	9
UKIVAS	Musculoskeletal and Orthopaedics	WSN	19
UK-ROX	Critical Care	WSN	16
UNBIASED: Understanding Inequalities and Barriers to Accessing Diabetes Technology (Interview Study)	Children	S&O	8
UNBIASED: Understanding Inequalities and Barriers to Accessing Diabetes Technology (Interview Study)	Children	WSN	3
UNCORKED	Trauma and Emergency Care	WSN	434
UNCORKED	Trauma and Emergency Care	S&O	213
WHiTE 11- FRUITI	Trauma and Emergency Care	S&O	3

APPENDIX 2 - Staff Publications – 2024-2025 Mersey and West Lancashire Teaching Hospitals

Staff academic output

Several departments at MWL, including (but not limited to) Burns and Plastics, Critical Care, Stroke, Paediatrics, etc, have been very active academically, producing a high volume of articles, published in peer reviewed journals, and poster presentations and abstracts at international conferences. The list below has been provided by the library services at the Trust, and it is not meant to be exhaustive.

Article details	Article Type	Staff Group	Impact Factor
Abdalla, M; Abdelrahim, M et al. (2024). **Anatomical Variations of the Bifurcation Levels of the Common Carotid Artery and Superior Thyroid Artery**. *Cureus*. 16(10), p.e71120. [Online]. Available at: http://dx.doi.org/10.7759/cureus.71120 [Accessed 18 October 2024]	Research article	Medical and Dental	1.1
Ali, H; Gasimmalla, O (2024). **A rare cardiac mass**. *BMJ*. 385.Article Number e078072. [Online]. Available at: https://doi.org/10.1136/bmj-2023-078072 [Accessed 13 June 2024]	Case studies/case series	Medical and Dental	93.7
Ariyaratne, S; Iyengar, KP; et al. (2023). **Authors' response to the Letter to the Editor: Re-evaluating the role of AI in scientific writing: a critical analysis**. *Skeletal Radiology*. 52, p.2489. [Online]. Available at: https://doi.org/10.1007/s00256-023-04405-5 [Accessed 19 April 2024]	Letters/comments/editorials/book reviews	Medical and Dental	2.1

Notes

- **Article**
  The articles included in this document were discovered (through alerts set up on various medical databases or via staff informing us of a new publication) between April 2024 and the end of March 2025. Please note the publication date given - they may have been published outside of these dates (it can take a long time for articles to appear in databases). We always include the articles within the year we discovered them as they will not have been included in the previous year's data)
- **Article type**
  This can be one of the following:

- Conference abstracts/posters
- Case studies/Case series (including ones with lit reviews)
- Research articles (any type of research, including qualitative and systematic reviews)
- Letters/comments/editorials/book reviews

- **Staff Group**
  - This is based on ESR Staff Groups.
  - The staff group selected is based on either the staff group of the corresponding author (if STHK staff) or from the first name STHK author in the author list.
  - The term collaborator is used for a member of staff listed as part of a research group participating in the research article, but not listed as an author.
- **Impact Factor**
  - This is taken from the relevant journal's website and is correct on the day the article was added to the staff publications list.
  - If an impact factor isn't provided on the journal's website it will be listed as N/A (not available)
  - Some journals only provide a 2-Year and 5-Year Journal, these are also listed here as N/A (not available)

Reference	Article Type	Professional Group	1-Year Impact
Abdalla, M; Abdelrahim, M et al. (2024). **Anatomical Variations of the Bifurcation Levels of the Common Carotid Artery and Superior Thyroid Artery**. *Cureus*. 16(10), p.e71120. [Online]. Available at: http://dx.doi.org/10.7759/cureus.71120 [Accessed 18 October 2024]	Research article	Medical and Dental	1.1
Adlan, A.; Iyengar, KP. et al. (2025). **Relationship between the Articular Cartilage Thickness of the Patella and Trochlea in Trochlear Dysplasia Compared to Normal Knees.** *Journal of Arthroscopy & Joint Surgery.* 12(1), pp.5-8. [Online]. Available at: https://journals.lww.com/jajs/fulltext/2025/01000/relationship_between_the_articular_cartilage.2.asp [Accessed 30 December 2024].	Research article	Medical and Dental	N/A
Adlan, A; Iyengar, KP et al. (2024). **The "Mustache sign:" An ancillary radiological sign for detecting L5/S1 spondylolisthesis**. *Journal of Craniovertebral Junction & Spine*. 15(3), pp.343-346. [Online]. Available at: https://dx.doi.org/10.4103/jcvjs.jcvjs_69_24 [Accessed 2 October 2024]	Research article	Medical and Dental	1.4
Agarwal, A; Iyengar, KP et al. (2024). **"Small but mighty" — A radiologists' primer for ultrasound imaging of the smaller peripheral nerves**. *Skeletal Radiology*. Pub online 03 Dec. [Online]. Available at: https://doi.org/10.1007/s00256-024-04844-8 [Accessed 11 December 2024]	Research article	Medical and Dental	1.9

Reference	Article Type	Professional Group	1-Year Impact
Agrawal, N.; Iyengar, KP. et al. (22 August 2024). **BAASIK technique: an innovative single needle technique of performing shoulder corticosteroid injections.** J*ournal of Ultrasound.* Online ahead of print. [Online]. Available at: https://doi.org/10.1007/s40477-024-00948-y [Accessed 29 August 2024].	Research article	Medical and Dental	1.3
Ahmed, M; Abdelrahim, M et al. (2024). **Felty Syndrome Presented with Candida albicans Lung Abscess Without Arthritis: A Case Report**. *Cureus*. 16(8), p.e66989. [Online]. Available at: https://doi.org/10.7759/cureus.66989 [Accessed 2 October 2024]	Case studies/case series	Medical and Dental	1.1
Ahmed, S.; Iyengar, KP. et al. (2024). **Luschka's tubercle and snapping scapula syndrome: an anatomical and clinical discourse.** *European Journal of Anatomy.* 28(4), p.-. [Online]. Available at: https://doi.org/10.52083/HVJP6884 [Accessed 30 July 2024].	Case studies/Case series	Medical and Dental	N/A
Ahmed, S.; Iyengar, KP. et al. (2025). **Assessing Chat Generative Pre-training Transformer's Proficiency in Identifying, Diagnosing, and Managing Orthopedic Fractures.** *Journal of Arthroscopy and Joint Surgery.* 12(1), pp.27-30. [Online]. Available at: https://journals.lww.com/jajs/fulltext/2025/01000/assessing_chat_generative_pre_training.6.aspx#:~:t [Accessed 30 December 2024].	Research article	Medical and Dental	N/A
Ajay, A; Ajay, H et al. (2024). **Relaxin agonists under preclinical and early clinical investigation for the treatment of heart failure**. *Expert Opinion on Investigational Drugs*. Pub online 6 Dec. [Online]. Available at: https://doi.org/10.1080/13543784.2024.2438663 [Accessed 11 December 2024]	Research article	Medical and Dental	4.9
Ajmera, P; Iyengar, KP et al. (2024). **Response to: ChatGPT's limited accuracy in generating anatomical images for medical**. *Skeletal Radiology*. epub 20 Mar. [Online]. Available at: https://doi.org/10.1007/s00256-024-04656-w [Accessed 19 April 2024]	Letters/comments/editorials/book reviews	Medical and Dental	2.1
Akisha, YM; Meah, N et al. (20 Nov 2024). **Low-Dose Oral Minoxidil Initiation for Patients with Hair Loss: An International Modified Delphi Consensus Statement.** *JAMA Dermatology.* Online ahead of print [Online]. Available at: https://jamanetwork.com/journals/jamadermatology/article-abstract/2826573 [Accessed 3 December 2024].	Research article	Medical and Dental	11.5
Ali, H; Gasimmalla, O (2024). **A rare cardiac mass**. *BMJ*. 385.Article Number e078072. [Online]. Available at: https://doi.org/10.1136/bmj-2023-078072 [Accessed 13 June 2024]	Case studies/case series	Medical and Dental	93.7

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Ali, SS; Nune, A et al. (2025). **Determinants of physical function, as measured using PROMIS PF-10a, in patients with rheumatoid arthritis: results from the international COVID-19 Vaccination in Autoimmune Diseases (COVAD) study**. *Rheumatology Advances in Practice*. 9(1), p.rkae154. [Online]. Available at: https://doi.org/10.1093/rap/rkae154 [Accessed 29 January 2025]	Research article	Medical and Dental	2.1
Allan, AY; Gill, P. (2025). **Exploring Rhinophyma treatment: An observational study comparing the results of the cold blade technique and ablative fractional CO2-laser**. *Journal of Plastic, Reconstructive & Aesthetic Surgery*. 102, pp.9-10. [Online]. Available at: https://www.jprasurg.com/article/S1748-6815(25)00006-3/abstract [Accessed 29 January 2025]	Letters/comments/editorials/book reviews	Medical and Dental	2
Alobaida, M.; Abdul-Rahim, AH. et al. (23 August 2024). **Impact of bridging thrombolysis versus endovascular thrombectomy alone on outcomes in anticoagulated patients with atrial fibrillation and acute ischaemic stroke.** *European Journal of Neurology.* Early View Online. [Online]. Available at: https://onlinelibrary.wiley.com/doi/10.1111/ene.16453 [Accessed 29 August 2024].	Research article	Medical and Dental	4.5
Alobaida, M.; Hill, A. et al. (2024). **Systematic Review and Meta-Analysis of Prehospital Machine Learning Scores as Screening Tools for Early Detection of Large Vessel Occlusion in Patients with Suspected Stroke.** *Journal of the American Heart Association*. 14 Jun 2024, Ahead of Print. [Online]. Available at: https://doi.org/10.1161/JAHA.123.033298 [Accessed 18 June 2024].	Research article	Medical and Dental	5.4
Al-Qudah, A.; Zone, A.; Jewitt, C.; Fuller, R.; Booth, S.; Rimmer, C.; Haslam, Z. (Collaborators) Trainee Emergency Research Network (TERN). **Subarachnoid haemorrhage in the emergency department (SHED): a prospective, observational, multicentre cohort study.** *Emerg Med J.* 2024 Sep 17:emermed-2024-214068. doi: 10.1136/emermed-2024-214068. Epub ahead of print. PMID: 39266054.	Research article	Medical and Dental	2.7
Ammar, A; Sharief, M et al. (2024). **Conduction system pacing versus biventricular pacing in heart failure with reduced ejection fraction and electrical dyssynchrony**. *Frontiers in Cardiovascular Medicine*. 11, Article No. 1495689. [Online]. Available at: https://doi.org/10.3389/fcvm.2024.1495689 [Accessed 2 January 2025]	Research article	Medical and Dental	2.8
Andrew, Tom W, Pritchard-Jones, Rowan; Et al. (2024). **An annual review of key advances in evidence-based plastic surgery, A synopsis from the leads of the BAPRAS Research & Innovation, Education, and Trainees Committees.** *JPRAS*. 92(PA1-A7) [Online]. Available at: http://dx.doi.org/10.1016/j.bjps.2024.02.076 [Accessed 22 May 2024].	Research article	Medical and Dental	N/A

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Ariyaratne S; Iyengar K.P; Et al. (2024). **Could ChatGPT Pass the UK Radiology Fellowship Examinations?** *Academic Radiology*. 31(5), pp.2178 - 2182. [Online]. Available at: https://doi.org/10.1016/j.acra.2023.11.026 [Accessed 22 May 2024].	Research article	Medical and Dental	4.8
Ariyaratne, S; Ivengar, KP et al. (2024). **Anatomy and Pathologies of the Spinous Process**. *Diseases*. 12(12), p.302. [Online]. Available at: https://doi.org/10.3390/diseases12120302 [Accessed 2 January 2025]	Research article	Medical and Dental	2.9
Ariyaratne, S; Iyengar, KP et al. (2024). **Authors' Response: The Accuracy of the Multimodal Large Language Model GPT-4 on Sample Questions from the Interventional Radiology Board Examination**. *Academic Radiology*. epub 20 June. [Online]. Available at: https://doi.org/10.1016/j.acra.2024.05.025 [Accessed 27 June 2024]	Letters/comments/editorials/book reviews	Medical and Dental	3.8
Ariyaratne, S; Iyengar, KP; Botchu, R. (2023). **Author response to: Comment on: Will collaborative publishing with ChatGPT drive academic writing in the future?** *BJS*. 110(12), p.1894. [Online]. Available at: https://doi.org/10.1093/bjs/znad295 [Accessed 19 April 2024]	Letters/comments/editorials/book reviews	Medical and Dental	9.6
Ariyaratne, S; Iyengar, KP; et al. (2023). **Authors' response to the Letter to the Editor: Re-evaluating the role of AI in scientific writing: a critical analysis**. *Skeletal Radiology*. 52, p.2489. [Online]. Available at: https://doi.org/10.1007/s00256-023-04405-5 [Accessed 19 April 2024]	Letters/comments/editorials/book reviews	Medical and Dental	2.1
Ariyaratne, S; Iyengar, KP; et al. (2023). **Authors' response to the Letter to the Editor**. *Skeletal Radiology*. 52, p.2491. [Online]. Available at: https://doi.org/10.1007/s00256-023-04418-0 [Accessed 19 April 2024]	Letters/comments/editorials/book reviews	Medical and Dental	2.1
Ashe, M; Mukhtar, K; Murtagh, L. (2025). **P075 Awake upper limb plastic surgery list – evaluation of a well established service shows good patient satisfaction and time efficiency**. *Regional Anesthesia & Pain Medicine*. 49(Suppl 1), pp.A304-A305. [Online]. Available at: https://doi.org/10.1136/rapm-2024-ESRA.479 [Accessed 11 December 2024]	Conference abstracts/posters	Medical and Dental	5.1
Atkin, C.; Varia, R. et al. (2024). **Provision of medical Same Day Emergency Care services within the UK: analysis from the Society for Acute Medicine Benchmarking Audit.** *medRxiv.* Preprint (14 Oct 2024) [Online]. Available at: https://www.medrxiv.org/content/10.1101/2024.10.13.24315407v1 [Accessed 30 December 2024].	Research article	Medical and Dental	N/A

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Atkin, C; Varia, R; et al. (2024). **Evaluating acute medical service performance against assessment time metrics: the Society for Acute Medicine Benchmarking Audit 2023 (SAMBA23)**. *medRxiv*. Pub online 15 Jul. [Online]. Available at: https://doi.org/10.1101/2024.07.15.24310421 [Accessed 20 September 2024]	Research article	Medical and Dental	N/A
Azam, M; Elshazly, M; Jmor, S. (2024). **EP366 A single surgeon experience of total extraperitoneal inguinal hernia repair in a district general hospital**. *British Journal of Surgery*. 111(Suppl 8), p... [Online]. Available at: https://doi.org/10.1093/bjs/znae197.483 [Accessed 17 October 2024]	Conference abstracts/posters	Medical and Dental	8.6
Barmen, B; Nune, A et al. (2024). **Clinical and Immunological Profile of Systemic Lupus Erythematosus: A 5-year Retrospective Analysis from Northeast India**. *Journal of The Association of Physicians of India*. 72(3), pp.32-35. [Online]. Available at: https://www.japi.org/article/japi-72-3-32 [Accessed 17 May 2024]	Research article	Medical and Dental	N/A
Barton, G., Rickard, C.M. & Roberts, J.A. **Continuous infusion of beta-lactam antibiotics in critically ill patients with sepsis: implementation considerations.** *Intensive Care Med* (2024). https://doi.org/10.1007/s00134-024-07650-x	Research article	Medical and Dental	27.1
Barton, G; Et al. (2025). **Considerations for beta-lactam antimicrobial continuous infusion. Authors' reply to Massart et al. and Marzaroli et al.** *Intensive Care Medicine*. 51(1), pp.230-231. [Online]. Available at: https://dx.doi.org/10.1007/s00134-024-07724-w [Accessed 6 March 2025].	Letters/comments/editorials/book reviews	Medical and Dental	29.6
Bekhelt, M; Almadhoob, F et al. (2025). **Mechanisms underpinning the effect of exercise on the non-alcoholic fatty liver disease**. *EXCLI Journal*. 24(.), pp.238-266. [Online]. Available at: https://www.excli.de/excli/article/view/7718 [Accessed 11 March 2025]	Research article	Medical and Dental	3.8
Bhatia, C; Balraj, A; Seenivasan, A. (2024). **Initiation of therapeutic hypothermia in neonates with hypoxic ischaemic encephalopathy**. *Infant*. 20(6). [Online]. Available at: https://www.infantjournal.co.uk/journal_article.html?id=7427 [Accessed 2 January 2025]	Research article	Medical and Dental	N/A
Bola, B; Et al. (2025). **The Promise of Radiotherapy in High-Risk Non-Muscle Invasive Bladder Cancer.** *Cancers*. 17(4), p.628. [Online]. Available at: https://www.doi.org/10.3390/cancers17040628 [Accessed 6 March 2025].	Research article	Medical and Dental	4.9
Booker, J.; Woodward, C. et al. (2024). **Creating evidence-based engaging online learning resources in neuroanatomy.** *Anatomical Sciences Education*. 17(3), pp.605-19. [Online]. Available at: doi: 10.1002/ase.2367. [Accessed 28 May 2024].	Research article	Medical and Dental	7.3

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Brush, A.; Lloyd, M. et al. (2024). **A mixed methods evaluation of the appropriateness of hospital on-call pharmacy service use.** *International Journal of Pharmacy Practice.* 32(1), pp.i45-i46. [Online]. Available at: https://doi.org/10.1093/ijpp/riae013.057 [Accessed 28 May 2024].	Research article	Medical and Dental	1.8
Bucci, T; Abdul-Rahim, AH et al. (2024). **Incident dementia in ischaemic stroke patients with early cardiac complications: A propensity-score matched cohort study**. *European Stroke Journal*. Pub online 02 Nov(.), p... [Online]. Available at: https://doi.org/10.1177/23969873241293573 [Accessed 4 November 2024]	Research article	Medical and Dental	5.9
Cameron, A; Abdul-Rahim, AH et al. (2024). **Natriuretic Peptides to Classify Risk of Atrial Fibrillation Detection After Stroke Analysis of the BIOSIGNAL and PRECISE Cohort Studies**. *Neurology*. 103(3), p.e209625. [Online]. Available at: https://doi.org/10.1212/wnl.0000000000209625 [Accessed 5 July 2024]	Research article	Medical and Dental	10.1
Cancelloni, V; Abdul-Rahim, A. H; Et al. (2024). **Reperfusion therapies in patients with acute ischaemic stroke and atrial fibrillation: data on safety and effectiveness from a multi-centre cohort study.** *Neurological Sciences.* [Online]. Available at: https://dx.doi.org/10.1007/s10072-024-07555-z [Accessed 7 June 2024].	Research article	Medical and Dental	3.3
Caso, V; Abdul-Rahim, AH et al. (2024). **European Stroke Organisation (ESO) Guidelines on the diagnosis and management of patent foramen ovale (PFO) after stroke**. *European Stroke Journal*. epub 16 May(.), p... [Online]. Available at: https://doi.org/10.1177/23969873241247978 [Accessed 17 May 2024]	Research article	Medical and Dental	6.1
Cattermole, R. et al. (2024). **Causes of sudden unexpected death in infants with and without pre-existing conditions: a retrospective autopsy study.** *BMJ Paediatrics Open.* 8(1), p.e002641. [Online]. Available at: https://doi.org/10.1136/bmjpo-2024-002641 [Accessed 29 August 2024].	Research article	Medical and Dental	2
Chaddock, NJM et al; Dawson, J & Graham, D (Collaborators). (2024). **Age, anticoagulants, hypertension and cardiovascular genetic traits predict cranial ischaemic complications in patients.** *Annals of the Rheumatic Diseases.* Online Ahead of Print (Oct 3). [Online]. Available at: https://ard.bmj.com/content/early/2024/10/03/ard-2024-225515 [Accessed 22 October 2024].	Research article	Medical and Dental	20.3

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Chadwick, T; Davis, J; Bitar, W; Pankaja, S. (2024). **Placental mesenchymal dysplasia: a rare case associated with second trimester fetal growth restriction.** *BMC Pregnancy and Childbirth.* 24 (Article 786) [Online]. Available at: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-024-06960-8 [Accessed 3 December 2024].	Case studies/Case series	Medical and Dental	2.8
Chapala, S.; Iyengar, KP. et al. (2024). **Isolated spontaneous non-insertional tear of the iliopsoas tendon in an elderly patient: significance of ultrasound imaging**. *Journal of Ultrasound*. Online ahead of print (Jul 26.), [Online]. Available at: https://doi.org/10.1007/s40477-024-00945-1 [Accessed 30 July 2024].	Research article	Medical and Dental	1.3
Chapala, S.; Iyengar, KP. et al. (2024). **Painful Os Peroneum Syndrome Secondary to Hydroxyapatite Deposition Disease.** *Indian Journal of Radiology & Imaging.* 35(1), pp.188-191. [Online]. Available at: https://www.thieme-connect.com/products/ejournals/pdf/10.1055/s-0044-1789190.pdf [Accessed 30 December 2024].	Case studies/Case series	Medical and Dental	1
Chapala, S; Iyengar, K.P.; Et al. (2025). **Pictorial Review of Paediatric Limp.** *Pediatric Reports*. 17(1), [Online]. Available at: doi.org/10.3390/pediatric17010014 [Accessed 6 March 2025].	Research article	Medical and Dental	1.2
Charlambous, C.; Kwaees, T. et al. (2024). **The SAInT study: a protocol for a randomized controlled trial of steroid injection for subacromial pain syndrome using the anterolateral versus posterior approach**. *Bone & Joint Open.* 5(9), pp.729-35. [Online]. Available at: https://doi.org/10.1302/2633-1462.59.bjo-2023-0138.r1 [Accessed 12 September 2024].	Research article	Medical and Dental	2.8
Chen, J.P; Nune, A; Et al. (2024). **AB1645-PARE DISEASE FLARES IN PATIENTS WITH RHEUMATOID ARTHRITIS FOLLOWING COVID-19 BREAKTHROUGH INFECTION: RESULT FROM COVAD E-SURVEY STUDY.** *Annals of the Rheumatic Diseases.* 83(1), pp.2198-2199. [Online]. Available at: https://dx.doi.org/10.1136/annrheumdis-2024-eular.981 [Accessed 14 August 2024].	Conference abstracts/posters	Medical and Dental	20.3
Chen, Y; Ditchfield, C et al. (2024). **Exploring the prognostic impact of triglyceride-glucose index in critically ill patients with first-ever stroke: insights from traditional methods and machine learning-based mortality prediction**. *Cardiovascular Diabetology*. 23, Article number 443. [Online]. Available at: https://doi.org/10.1186/s12933-024-02538-y [Accessed 19 December 2024]	Research article	Nursing and Midwifery	8.5

Reference	Article Type	Professional Group	1-Year Impact
Chkir, Baraa; Sivaji, Aroon. (2024). **Unravelling Kikuchi-Fujimoto Disease: A Unique Presentation of Recurrent Aseptic Meningitis in a District Hospital Setting.** *Cureus.* 16(12), p.e74897. [Online]. Available at: http://dx.doi.org/10.7759/cureus.74897 [Accessed 9 January 2025].	Research article	Medical and Dental	1.1
Chng, SY; Tern, MJW et al. (2025). **Ethical considerations in AI for child health and recommendations for child-centered medical AI.** *njp digital medicine.* 8(152). [Online]. Available at: https://www.nature.com/articles/s41746-025-01541-1#citeas [Accessed 19 March 2025].	Research article	Medical and Dental	12.4
Choi, S; Hill, A; Abdul-Rahim, A et al. (2024). **Early statin use for secondary prevention in patients with atrial fibrillation and recent ischaemic stroke**. *Conference poster from 10th European Stroke Organisation Conference*, 15-17 May 2024, Basel, Switzerland.	Conference abstracts/posters	Medical and Dental	N/A
Choi, SE; Hill, A; Irvining, G; Abdul-Rahim, AH et al. (2024). **Early statin use is associated with improved survival and cardiovascular outcomes in patients with atrial fibrillation and recent ischaemic stroke: A propensity-matched analysis of a global federated health database**. *European Stroke Journal*. epub 10 Sep. [Online]. Available at: https://doi.org/10.1177/23969873241274213 [Accessed 11 September 2024]	Research article	Medical and Dental	5.8
Conway, L; Wignall, J et al. (2025). **The Incomplete V-Y Flap: A Useful Design Modification of the Conventional V-Y Flap Exampled with a Case Series of Piloninidal Sinus Excision Defects.** *Annals of Plastic Surgery.* Online ahead of print. [Online]. Available at: https://journals.lww.com/annalsplasticsurgery/abstract/9900/the_incomplete_v_y_flap__a_useful_design [Accessed 19 March 2025].	Research article	Medical and Dental	NA
Cranwell, W; Meah, N et al. (2024). **Real-world effectiveness and safety of tofacitinib for alopecia areata: A retrospective cohort study of 202 patients**. *Australasian Journal of Dermatology.* epub 03 June. [Online]. Available at: https://doi.org/10.1111/ajd.14325 [Accessed 12 June 2024]	Research article	Medical and Dental	N/A
Cronin, T; Gendy, D et al. (2024). **What impact does widening participation to medicine have on the medical workforce in the UK: a scoping review.** *Education for Primary Care.* Online ahead of print. [Online]. Available at: https://www.tandfonline.com/doi/full/10.1080/14739879.2024.2426130 [Accessed 3 December 2024].	Research article	Medical and Dental	1.5
Cross, A et al. (2024). **Use of the Therapy Outcome Measure in community intermediate care: results of a service evaluation**. *International Journal of Therapy &*	Research article	Allied Health Professional	N/A

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Rehabilitation. 31(9), pp.1-10. [Online]. Available at: https://doi.org/10.12968/ijtr.2023.0034 [Accessed 8 October 2024]			
Cross, A; Raaj, S; Krishnamoorthy, B. (2024). **Use of Therapy Outcome Measures (TOMs) and Australian Therapy Outcome Measures (AusTOMs) in community physiotherapy and community occupational therapy services: a scoping review.** *Disability and Rehabilitation* pp.1-9. [Online]. Available at: https://www.tandfonline.com/doi/full/10.1080/09638288.2024.2433638#:~:text=Use%20of%20Therapy%20Outc [Accessed 3 December 2024].	Research article	Allied Health Professional	2.1
Dablouk, M; Et al. (2024). **Recurrence of Retinopathy of Prematurity Following Anti-vascular Endothelial Growth Factor (Anti-VEGF) Therapy: A Systematic Review and Meta-Analysis.** *Cureus*. 16(11), p.e73286. [Online]. Available at: http://dx.doi.org/10.7759/cureus.73286 [Accessed 21 November 2024].	Research article	Medical and Dental	1.1
Dablouk, M; Musa, A. (2024). **Cerebral Venous Sinus Thrombosis Following Varicella Infection: A Case Report**. *Cureus*. 16(10), p.e72448. [Online]. Available at: https://doi.org/10.7759/cureus.72448 [Accessed 4 November 2024]	Case studies/case series	Medical and Dental	1.1
Darchini-Maragheh, E; Meah, N et al. (2024). **Letter to the Editor: Low-dose oral minoxidil for the treatment of monilethrix: A retrospective review**. *JEADV: Journal of the European Academy of Dermatology & Venereology*. pub online 18 Sep. [Online]. Available at: https://doi.org/10.1111/jdv.20329 [Accessed 2 October 2024]	Letters/comments/editorials/book reviews	Medical and Dental	10.7
Daurat, JL; Thomson-Glover, R et al. (2024). **Context, clarity and conversation: Spotting the Signs updated toolkit.** *Sex Transm Infect.* 100(7), p.474. [Online]. Available at: 10.1136/sextrans-2024-056213. [Accessed 22 October 2024].	Letters/comments/editorials/book reviews	Medical and Dental	3.6
Dawar, Heather. (2024). **Medication-related osteonecrosis of the jaw: Shortfalls in UK-based guidance for management of established cases.** *Oral Surgery.* 17(4), p.393. [Online]. Available at: https://doi.org/10.1111/ors.12888 [Accessed 11 October 2024].	Letters/comments/editorials/book reviews	Medical and Dental	N/A
Dawson, J; Abdul-Rahim, AH; Kimberley, TJ. (2024). **Neurostimulation for treatment of post-stroke impairments**. *Nature Reviews Neurology*. epub 03 April [Online]. Available at: https://doi.org/10.1038/s41582-024-00953-z [Accessed 4 April 2024]	Research article	Medical and Dental	N/A

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Day, A.W.; Floyd, M.S. et al. (2024). **Letter to editor re: (2024) Smoking is not associated with wound complications in augmented urethroplasty: a NSQIP analysis. Int Urol Nephrol. https://doi.org/10.1007/s11255-024-04085-7 by Cahill et al.** International Urology and Nephrology. [Online]. Available at: https://doi.org/10.1007/s11255-024-04138-x [Accessed 8 July 2024].	Letters/comments/editorials/book reviews	Medical and Dental	1.8
Day, AW; Ravichandran, S; Khadr, RN; Floyd Jr, MS. (2024). **Letter to editor re: Chen et al. (2024) Management of spinal cord injury patients with neurogenic lower urinary tract dysfunction using minimally invasive and surgical therapies in Taiwan. Int Urol Nephrol 56:1205–1216**. *International Urology and Nephrology*. epub 13 Apr. [Online]. Available at: https://link.springer.com/article/10.1007/s11255-024-04051-3 [Accessed 19 April 2024]	Letters/comments/editorials/book reviews	Medical and Dental	2
De Souza, K.; Ashall, B. et al. (2024). **P-154 Palliative upper gastrointestinal (UGI) cancer health and wellbeing – a place for support and preparation.** *BMJ Supportive & Palliative Care.* 14(Suppl. 4), p.A68. [Online]. Available at: https://doi.org/10.1136/spcare-2024-HUNC.172 [Accessed 5 February 2025].	Conference abstracts/posters	Nursing and Midwifery	2
Deb, R; Laokulrath, N; Chagla, L; Hoon Tan, P. (2024). **Challenges and Clinical Relevance of Modern Breast Pathology Reporting: Your Questions Answered**. *Pathobiology*. epub 08 Feb(.), pp.1-13. [Online]. Available at: https://doi.org/10.1159/000536638 [Accessed 13 June 2024]	Research article	Medical and Dental	5
Defty, C; Krishna, Y; Khan, MAA; Sharma, N; Tehrani, H. (2025). **Follicular Lymphoma Detected in a Patient Undergoing Mohs Surgery: A Case Report**. *Cureus*. 17(1), p.e77583. [Online]. Available at: https://doi.org/10.7759/cureus.77583 [Accessed 27 February 2025]	Case studies/case series	Medical and Dental	1.1
DeLacey, S.; Ng, S.M. et al. (2025). **A Systematic Review of Interventions for the Transition to Adult Healthcare for Young People with Diabetes.** *Current Diabetes Reports.* 25(21) [Online]. Available at: https://link.springer.com/article/10.1007/s11892-025-01578-2 [Accessed 6 February 2025].	Research article	Medical and Dental	5.2
Deshmukh, H; Saunders, S; et al. (2024). **Clinical features of type 1 diabetes in older adults and the impact of intermittently scanned continuous glucose monitoring: An Association of British Clinical Diabetologists (ABCD) study**. *Diabetes, Obesity and Metabolism*. 26(4), pp.1333-1339. [Online]. Available at: https://doi.org/10.1111/dom.15434 [Accessed 19 April 2024]	Research article	Medical and Dental	N/A
Dey, M.; Nune, A. et al. (2024) **COVID-19 vaccination-related delayed adverse events among people with rheumatoid arthritis: results from the international COVAD**	Research article	Medical and Dental	3.2

Reference	Article Type	Professional Group	1-Year Impact
survey. *Rheumatology International.* 2024 Nov 6. Available at: doi: 10.1007/s00296-024-05742-x. Epub ahead of print. PMID: 39503760. [Accessed 13 November 2024].			
Dlugatch, R; Ng, M et al. (2024). **Understanding inequities in access to diabetes technologies in children and young people with type 1 diabetes: Qualitative study of healthcare professionals' perspectives and views.** *Diabetic Medicine.* Online ahead of print [Online]. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/dme.15486?msockid=0675aec9083d632329d7bdf709aa625b [Accessed 3 December 2024].	Research article	Medical and Dental	6.9
Dunlop, CL; Thompson, A et al. (2024). **Adapting the WHO hand hygiene 'reminders in the workplace' to improve acceptability for healthcare workers in maternity settings worldwide: a mixed methods study**. *BMJ Open*. 14(9), p.e083132. [Online]. Available at: https://doi.org/10.1136/bmjopen-2023-083132 [Accessed 2 October 2024]	Research article	Nursing and Midwifery	2.4
Elsheikh, S; Hill, A; Abdul-Rahim, A et al. (2024). **Left atrial appendage occlusion versus direct oral anticoagulants in the prevention of ischaemic stroke in patients with atrial fibrillation**. *Conference poster from 10th European Stroke Organisation Conference,* 15-17 May 2024, Basel, Switzerland	Conference abstracts/posters	Medical and Dental	N/A
Eustace; I; Hill, AR; et al. (2025). **Integrated care management for patients following acute stroke: a systematic review**. *QJM: An International Journal of Medicine*. Pub online: 24 Jan, [Online]. Available at: https://doi.org/10.1093/qjmed/hcaf029 [Accessed 29 January 2025]	Research article	Medical and Dental	7.3
Farook, FF; Nizam, MNM; et al. (2024). **Association between mouth rinse use and changes in blood pressure: A systematic review and meta-analysis with trial sequential analysis**. *International Journal of Dental Hygiene*. 22(1), pp.65-77. [Online]. Available at: https://doi.org/10.1111/idh.12714 [Accessed 19 April 2024]	Research article	Medical and Dental	N/A
Fitzpatrick, A; et al. (2024). **Prognostic factors for outcomes following surgical stabilization of rib fractures: A review of the literature**. *Injury*. 55(11), p.111778. [Online]. Available at: https://doi.org/10.1016/j.injury.2024.111778 [Accessed 19 August 2024]	Research article	Medical and Dental	2.2
Fitzpatrick, A; et al. (2024). Prognostic factors for outcomes following surgical stabilization of rib fractures: A review of the literature. Injury. 55(11), p.111778. [Online]. Available at: https://doi.org/10.1016/j.injury.2024.111778 [Accessed 19 Augus	Research article	Medical and Dental	1.1

Reference	Article Type	Professional Group	1-Year Impact
France-Ratcliffe, M; Abdul-Rahum, A; Et al. (2024). **Vitamin D and cardiovascular outcomes in multiple sclerosis.** *Multiple Sclerosis and Related Disorders*. 92, p.106155. [Online]. Available at: https://dx.doi.org/10.1016/j.msard.2024.106155 [Accessed 21 November 2024].	Research article	Medical and Dental	2.9
Gallagher, C; Et al. (2024). **GESTATIONAL DIABETES MELLITUS PREVENTION: A COMMENTARY.** *Practising Midwife*. 27(25), pp.24-28. [Online]. Available at: https://dx.doi.org/10.55975/TPDP7486 [Accessed 11 October 2024].	Research article	Nursing and Midwifery	N/A
Gavvala, SN; Iyengar, KP et al. (2024). **Coccygeal tumours unveiled: a retrospective cohort analysis from a tertiary referral centre**. *British Journal of Radiology*. 97(1162), pp.1636-1644. [Online]. Available at: https://doi.org/10.1093/bjr/tqae148 [Accessed 17 October 2024]	Research article	Medical and Dental	2.6
Kaul, A; Blacker, S; Parakh, J (Collaborators) et al. (2024). **Development and external validation of the 'Global Surgical-Site Infection' (GloSSI) predictive model in adult patients undergoing gastrointestinal surgery**. *BJS*. 111(6), p.znae129. [Online]. Available at: https://doi.org/10.1093/bjs/znae129 [Accessed 19 August 2024]	Research article	Medical and Dental	8.6
Graham, B; (Ahmed, A; Tissier, JH; Sugarman, M (Collaborators)). (2024). **Psychometric validation of a patient-reported experience measure for older adults attending the emergency department: the PREM-ED 65 study**. *Emergency Medicine Journal*. 41(11), pp.645-653. [Online]. Available at: https://doi.org/10.1136/emermed-2023-213521 [Accessed 29 January 2025]	Research article	Medical and Dental	2.8
Graham, SM; Saldanha, K (Collaborator) et al. (2024). **Identifying Research Priorities in Limb Reconstruction Surgery in the United Kingdom**. *Strategies in Trauma and Limb Reconstruction*. 19(1), pp.1-8. [Online]. Available at: https://stlrjournal.com/abstractArticleContentBrowse/STLR/67/19/1/35938/abstractArticle/Article [Accessed 2 October 2024]	Research article	Medical and Dental	0.8
Griffin, M; Abdul-Rahim; AH et al. (2024). **Challenging anticoagulation decisions in atrial fibrillation: a narrative review**. *Therapeutic Advances in Cardiovascular Disease*. Pub online 16 Oct. [Online]. Available at: https://doi.org/10.1177/17539447241290429 [Accessed 22 October 2024]	Research article	Medical and Dental	2.6
Hallinan, D. (2024). **Telehealth Versus In-person Musculoskeletal Physiotherapy Assessment: A Comparison of Specific Outcomes**. *Physiotherapy*. 123(Suppl. 1), pp.E91-E92. [Online]. Available at: https://doi.org/10.1016/j.physio.2024.04.111 [Accessed 28 June 2024]	Conference abstracts/posters	AHPs	3.1

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Hamoodi, Z; Barrett, E; Hitchcock, M; Earnshaw, K; Lipscombe, S; Sepesiova, L; Venugopal, V; Waraich, A; Zreik, NH et al. (2024). **The National Joint Registry Data Quality Audit of elbow arthroplasty.** *The Bone & Joint Journal.* 106-B(12), pp.1461-1468. [Online]. Available at: https://boneandjoint.org.uk/Article/10.1302/0301-620X.106B12.BJJ-2023-1372.R1 [Accessed 3 December 2024].	Research article	Medical and Dental	4.9
Hannah J, Dawson J; Et al. **The diagnosis and management of systemic autoimmune rheumatic disease-related interstitial lung disease: British Society for Rheumatology guideline scope**. *Rheumatol Adv Pract*. 2024 Apr 18;8(2):rkae056. doi: 10.1093/rap/rkae056. [Accessed 22 May 2024].	Research article	Medical and Dental	3.1
Hardman, L; Murray, E et al. (2025). **Hypospadias: The lay of the land**. *Journal of Plastic, Reconstructive & Aesthetic Surgery*. 102, pp.145-148. [Online]. Available at: https://doi.org/10.1016/j.bjps.2025.01.066 [Accessed 13 February 2025]	Letters/comments/editorials/book reviews	Medical and Dental	2
Harfoush, A; Abdul-Rahim, A; Maducolil, JE; Hume, C; Iijima, A et al. (2024). **Beyond Face Arm and Speech Test (Beyond FAST), a predicted probability-based stroke identification scale**. *Conference poster from 10th European Stroke Organisation Conference*, 15-17 May 2024, Basel, Switzerland	Conference abstracts/posters	Medical and Dental	N/A
Harries, M.; Meah, N. et al. (2025). **GRASS-UK: The Global Register of Alopecia areata disease Severity and treatment Safety- United Kingdom: importance of re.** *Clinical and Experimental Dermatology.* [Online]. Available at: https://academic.oup.com/ced/advance-article-abstract/doi/10.1093/ced/llaf055/7994561?redirectedFrom [Accessed 6 February 2025].	Research article	Medical and Dental	3.7
Harrison, NL; Omar, AM; Floyd Jr, MS. (2024). **Letter to the editor RE: Management of Anterior Urethral Stricture: A survey of Contemporary Practice of Iranian Urologists**. *Urology Journal*. 20, p.8208. [Online]. Available at: https://doi.org/10.22037/uj.v20i.8208 [Accessed 17 May 2024]	Letters/comments/editorials/book reviews	Medical and Dental	1.5
Harwood, S; Ashe, M; Plant, K; Geetha, V; Senathirajah, A. (2024). **EP056 Introduction of a thoracic trauma protocol including implementation of an erector spinae plane (ESP) catheter service in a busy district general hospital – A re-audit with consideration of our real-world experience and challenges**. *Regional Anesthesia & Pain Medicine*. 49(Suppl 1), p.A102. [Online]. Available at: https://doi.org/10.1136/rapm-2024-ESRA.129 [Accessed 12 December 2024]	Conference abstracts/posters	Medical and Dental	5.1

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Hassan, MS; Iyengar, KP; et al. (2024). **The clinical significance of indeterminate pulmonary nodules in patients with primary bone sarcoma: a systematic review**. *British Journal of Radiology*. 97(1156), pp.747-756. [Online]. Available at: https://doi.org/10.1093/bjr/tqae040 [Accessed 19 April 2024]	Research article	Medical and Dental	2.8
Hoad, KL; Abdul-Rahim, AH; et al. (2024). **Stroke-heart syndrome: Incidence and clinical outcomes of cardiac complications following intracerebral haemorrhage**. *European Stroke Journal*. epub 30 July 2024(.). [Online]. Available at: https://doi.org/10.1177/23969873241264115 [Accessed 31 July 2024]	Research article	Medical and Dental	5.8
Hubbard, T; Chagla, L et al. (2024). **The association of breast surgery ASPIRE - Breast pain pathway rapid evaluation project: Study update**. *European Journal of Surgical Oncology*. 50(Supple 1), Article Number: 108109. [Online]. Available at: https://doi.org/10.1016/j.ejso.2024.108109 [Accessed 17 May 2024]	Conference abstracts/posters	Medical and Dental	3.8
Hussein M, Shah AB, Shah BR, Iyengar KP, Botchu R. **Sciatic Nerve Entrapment from Cerclage Wiring in Intramedullary Nail Fixation.** *Indian J Radiol Imaging.* 2024 Jul 4;34(4):773-777. doi: 10.1055/s-0044-1787972. PMID: 39318585; PMCID: PMC11419752.	Research article	Medical and Dental	0.9
Hussein, M.; Iyengar, KP. et al. (2024). **Calcific Myonecrosis of the Leg: A Clinical and Diagnostic Dilemma.** *Apollo Medicine.* 21(Supp 1), pp.S59-S62. [Online]. Available at: https://doi.org/10.1177/09760016241281510 [Accessed 25 October 2024].	Case studies/case series	Medical and Dental	N/A
Hussein, Mohsin; Iyengar, Karthikeyan P; Et al. (2024). **Cubital tunnel syndrome: anatomy, pathology, and imaging**. *Skeletal Radiology*. 2024 [Online]. Available at: 10.1007/s00256-024-04705-4 [Accessed 22 May 2024].	Research article	Medical and Dental	2.1
Huttman, MM; Purves, R et al. (2024). **A Systematic Review to Summarise and Appraise the Reporting of Surgical Innovation: a Case Study in Robotic Roux-en-Y Gastric Bypass**. *Obesity Surgery*. epub 19 June. [Online]. Available at: https://doi.org/10.1007/s11695-024-07329-8 [Accessed 26 June 2024]	Research article	Medical and Dental	2.9
Ishiguchi, H; Abdul-Rahim, A; Et al. (2024). **Machine learning for stroke in heart failure with reduced ejection fraction but without atrial fibrillation: A post-hocanalysis of the WARCEF trial.** *European Journal of Clinical Investigation.* Online, [Online]. Available at: doi.org/10.1111/eci.14360 [Accessed 22 November 2024].	Research article	Medical and Dental	4.4

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Ishiguchi, H; Abdul-Rahim, AH et al. (2024 Nov 22). **Mortality Risk in Patients with Cardiac Complications Following Ischemic Stroke: A Report from the Virtual International Stroke Trials Archive.** *Journal of the American Heart Association*. Online ahead of print [Online]. Available at: https://www.ahajournals.org/doi/10.1161/JAHA.124.036799?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref. [Accessed 3 December 2024].	Research article	Medical and Dental	5.4
Ishiguchi, H; Abdul-Rahim, AH et al. (2024). **Incidence and Outcomes of Patients with Early Cardiac Complications After Intracerebral Hemorrhage: A Report From VISTA**. *Stroke*. pub online 02 Oct. [Online]. Available at: https://doi.org/10.1161/STROKEAHA.124.048189 [Accessed 3 October 2024]	Research article	Medical and Dental	7.8
Ishiguchi, H; Abdul-Rahim, AH et al. (2024). **Initial blood pressure and adverse cardiac events following acute ischaemic stroke: An individual patient data pooled analysis from the VISTA database**. *European Stroke Journal*. Pub online 30 Oct. [Online]. Available at: https://doi.org/10.1177/23969873241296391 [Accessed 31 October 2024]	Research article	Medical and Dental	5.9
Ishiguchi, H; Abdul-Rahim, AH et al. (2024). **Residual Risks of Thrombotic Complications in Anticoagulated Patients with Atrial Fibrillation: A Cluster Analysis Approach from the GLORIA-AF Registry**. *Journal of General Internal Medicine*. Pub online 25 Sep. [Online]. Available at: https://doi.org/10.1007/s11606-024-09045-6 [Accessed 30 September 2024]	Research article	Medical and Dental	4.3
Ishiguchi, H; Abdul-Rahim, AH et al. (2024). **Stroke-heart syndrome and early mortality in patients with acute ischaemic stroke using hierarchical cluster analysis: An individual patient data pooled analysis from the VISTA database**. *European Stroke Journal*. Pub Online 13 Oct. [Online]. Available at: https://doi.org/10.1177/23969873241290440 [Accessed 18 October 2024]	Research article	Medical and Dental	5.8
Iyengar, KP; Et al. (2014). **Can We Apply Pomodoro Technique in Academic Publishing?** *Apollo Medicine*. 21(2), pp.176-177. [Online]. Available at: https://www.doi.org/10.4103/am.am_193_23 [Accessed 11 October 2024].	Research article	Medical and Dental	N/A
Jack, B.A; Abrams, M; Et al. (2024). **Shining a Light in COVID-19 Darkness: The Impact of Hospital Chaplaincy Teams on Healthcare Professionals.** *Health and Social Care Chaplaincy.* 12(1). [Online]. Available at: https://www.doi.org/10.1558/hscc.27096 [Accessed 5 July 2024].	Research article	Add Prof Scientific and Technical	N/A
Jack, B; Abrams, M; Et al. (2024). **Working on the Clinical Frontline During the COVID-19 Pandemic: The Perceptions and Experiences of Hospital Chaplains.** *Health and Social Care Chaplaincy.* 12(1), p.N/A. [Online]. Available at: https://dx.doi.org/10.1558/hscc.26991 [Accessed 4 July 2024].	Research article	Add Prof Scientific and Technical	N/A

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Jain, V.K.; Iyengar, K.P. (2025). **Musculoskeletal infection, diagnosis and management.** *Journal of Clinical Orthopaedics and Trauma.* 62, p.102898. [Online]. Available at: https://www.journal-cot.com/article/S0976-5662(24)00567-8/abstract [Accessed 15 January 2025].	Letters/comments/editorials/book reviews	Medical and Dental	3.2
Jaiswal, R; Blower, E; Innes, H; Sripadam, R; Yiannoullou, P; Chagla, L. (2004). **The impact of body mass index on pathological complete response following neoadjuvant chemotherapy in operable breast cancer**. *European Journal of Surgical Oncology*. 50(Supple 1), Article Number: 108110. [Online]. Available at: https://doi.org/10.1016/j.ejso.2024.108110 [Accessed 17 May 2024]	Conference abstracts/posters	Medical and Dental	3.8
James, S.; Ng, S.M. et al. (2024). **Transition between paediatric and adult diabetes healthcare services: An online global survey of healthcare professionals' experiences and perceptions.** *Diabetes Research and Clinical Practice.* 214 [Online]. Available at: https://doi.org/10.1016/j.diabres.2024.111768 [Accessed 8 July 2024].	Research article	Medical and Dental	6.1
Jayaraman, M; Iyengar KP; Et al. (2014). **Nanomaterials in point-of-care diagnostics: Bridging the gap between laboratory and clinical practice.** *Pathology, research and practice.* 263, p.155685. [Online]. Available at: http://dx.doi.org/10.1016/j.prp.2024.155685 [Accessed 7 November 2024].	Research article	Medical and Dental	2.9
Jenko, N; Iyengar, K P; Et al. (2024). **Radiological angle assessment of Haglund's deformity: validation on Magnetic Resonance Imaging.** *The Foot.* 59(June 2024). [Online]. Available at: https://dx.doi.org/10.1016/j.foot.2024.102096 [Accessed 25 April 2024].	Research article	Medical and Dental	N/A
Jenko, N; Iyengar, KP; et al. (2024). **An evaluation of AI generated literature reviews in musculoskeletal radiology**. *The Surgeon*. epub 12 Jan. [Online]. Available at: https://doi.org/10.1016/j.surge.2023.12.005 [Accessed 19 April 2024]	Research article	Medical and Dental	2.5
Jeyaraman, M.; Iyengar, K P. et al. (2024). **Assessment of Needlestick and Sharps Injuries (NSSIs) Amongst Orthopaedic Surgeons in Clinical Practice: A Pan-India Cross-Sectional Study.** *Indian Journal of Orthopaedics*. [Online]. Available at: https://doi.org/10.1007/s43465-024-01178-4 [Accessed 28 May 2024].	Research article	Medical and Dental	1
Jeyaraman, M; Iyengar, K P; Et al. (2024). **Surgical Preparedness Index in Orthopaedics During the Coronavirus Disease 2019 (COVID-19) Pandemic**. *Cureus*. 16(3). [Online]. Available at: https://dx.doi.org/10.7759/cureus.56066 [Accessed 25 April 2024].	Research article	Medical and Dental	1.1

Reference	Article Type	Professional Group	1-Year Impact
Jeyaraman, M; Iyengar, KP et al. (2024). **Decoding the hidden realm: Molecular pioneering unravelling osteoarticular tuberculosis diagnosis**. *Journal of Clinical Orthopaedics and Trauma*. 56, p.102538. [Online]. Available at: https://doi.org/10.1016/j.jcot.2024.102538 [Accessed 2 October 2024]	Research article	Medical and Dental	3.2
John, V; Kim, K; Et al. (2024). **The role of multimodality imaging in the selection and management of patients treated with cytoreductive surgery and HIPEC**. **Abdominal Radiology**. 49(12), pp.4352 - 4364. [Online]. Available at: 10.1007/s00261-024-04441-2 [Accessed 7 November 2024].	Research article	Medical and Dental	2.3
Kabir, S.S.; Tijjani, B; Et al. (2024). **Global prevalence and correlates of mpox vaccine acceptance and uptake: a systematic review and meta-analysis.** *Communications Medicine*. [Online]. Available at: https://dx.doi.org/10.1038/s43856-024-00564-1 [Accessed 18 July 2024].	Research article	Medical and Dental	5.4
Kanani, A; Iyengar, KP et al. (2024). **Eccentric ripple sign of BAARISh - a new sign of venous pseudoaneurysm**. *Journal of Ultrasound*. Pub online 10 Oct. [Online]. Available at: https://doi.org/10.1007/s40477-024-00957-x [Accessed 17 October 2024]	Research article	Medical and Dental	1.3
Kennedy, JA; Ansari, SA et al. (2024). **Are trauma and orthopaedic consultant posts decreasing in frequency and increasing in subspecialisation?** *BMC Health Services Research*. 24(1508), p... [Online]. Available at: https://doi.org/10.1186/s12913-024-11478-y [Accessed 11 December 2024]	Research article	Medical and Dental	2.7
Khan, AA; Patel, P; Rachid, A. (2024). **The need to educate on effective reflective practice for international medical graduates**. *Medical Teacher*. epub 22 Apr. [Online]. Available at: https://doi.org/10.1080/0142159X.2024.2344620 [Accessed 3 May 2024]	Letters/comments/editorials/book reviews	Medical and Dental	4.7
Khan, B.G.; Et al. (2024). **Management of Scapula Fractures at a Level 1 Trauma Centre in the United Kingdom**. *Cureus*. 16(12), p.e74947. [Online]. Available at: http://dx.doi.org/10.7759/cureus.74947 [Accessed 9 January 2025].	Research article	Medical and Dental	1.1
Khan, F; Millette, D; Siddique, R; Siddique, H. (2024). **HIV-negative Kaposi sarcoma manifesting as foot lesion in a patient with diabetes mellitus: a case study.** *Wounds UK.* 20(1), pp.9-11. [Online]. Available at: https://wounds-uk.com/journal-articles/hiv-negative-kaposi-sarcoma-manifesting-as-foot-lesion-in-a-p [Accessed 19 April 2024]	Case studies/Case series	Medical and Dental	N/A
Khan, R.H.; Ahmed, Z. et al. (2024) **Dapagliflozin's Role in Heart Failure: An Overview of Clinical Trial Evidence.** *Cureus.* 2024 Oct 2;16(10):e70727. Available at: doi: 10.7759/cureus.70727. PMID: 39493115; PMCID: PMC11530358. [Accessed 13 November 2024]	Research article	Medical and Dental	1.1

Reference	Article Type	Professional Group	1-Year Impact
Knight, T; Green, C; et al. (2023). **Acute care models for older people living with frailty: a systematic review and taxonomy**. *BMC Geriatrics*. 23(.), p.809. [Online]. Available at: https://doi.org/10.1186/s12877-023-04373-4 [Accessed 19 April 2024]	Research article		N/A
Kumar, Mrityunjai; Et al. (2024). **Outcome Measures in intellectual disability: A Review and narrative synthesis of validated instruments.** *International Journal of Social Psychiatry.* Online First. [Online]. Available at: 10.1177/00207640241291517 [Accessed 7 November 2024].	Research article	Medical and Dental	2.5
Kustakin, K; Saeed, R. (2024). **Evaluation of the impact of a nephrologist led acute kidney Injury clinic in a large district general hospital.** *Nephrology Dialysis Transplantation.* 39(Sup 1). [Online]. Available at: https://dx.doi.org/10.1093/ndt/gfae069.1139 [Accessed 4 July 2024].	Research article	Medical and Dental	4.8
Kwaees, T A; Barter, R; Venugopal, V; Joseph, A D; Pydisetty, R. (2024). **Intra-articular steroids for the treatment of coxarthrosis; a retrospective cohort study comparing three contrast techniques.** *Archives of Orthopaedic and Trauma Surgery.* [Online]. Available at: https://dx.doi.org/10.1007/s00402-024-05371-w [Accessed 6 June 2024].	Research article	Medical and Dental	2.3
Kwasnicki, M; Pritchard-Jones, R; et al. (2024). **Quantifying postoperative recovery using wearable activity monitors following abdominal wall surgery: The AbTech trial**. *JPRAS*. 93(June), pp.281-289. [Online]. Available at: https://doi.org/10.1016/j.bjps.2024.04.048 [Accessed 17 May 2024]	Research article	Medical and Dental	2.7
Latham, T; Malhotra, P; Et al. (2024). **Construction of a decision model for donor testing in cases of suspected antibody-mediated transfusion-related-acute-lung-injury.** *Transfusion Medicine*. Online. [Online]. Available at: https://doi.org/10.1111/tme.13073 [Accessed 5 September 2024].	Research article	Medical and Dental	1.5
Lee, TS.; Pritchard-Jones, R. et al. (2024). **ASO Visual Abstract: Leg Lymphoedema After Inguinal and Ilio-Inguinal Lymphadenectomy for Melanoma: Results from a Prospective Randomized Trial.** *Annals of Surgical Oncology*. 31(-), pp.4609-4610. [Online]. Available at: https://doi.org/10.1245/s10434-024-15262-4 [Accessed 18 June 2024].	Conference abstracts/posters	Medical and Dental	3.7
Lewis, G. Hardy, K et al. (2024). **Evaluating the impact of differing completion rates of a face-to-face DIABETES self-management education programme on Patient Reported Outcome measures (DIABETES PRO): A feasibility trial protocol.** *Diabetic Medicine.* (Online ahead of print), p.e15430. [Online]. Available at: https://doi.org/10.1111/dme.15430 [Accessed 12 September 2024].	Research article	Medical and Dental	6.9

Reference	Article Type	Professional Group	1-Year Impact
Lewis, Gemma; Hardy, K; Et al. (2025). **Association between diabetes self-management education attendance, hospital admissions and mortality in type 2 diabetes: A cohort analysis protocol.** *Diabetes, Obesity and Metabolism.* Pre-Publication (1), p.1. [Online]. Available at: https://doi.org/10.1111/dom.16257 [Accessed 6 March 2025].	Research article	Medical and Dental	5.4
Liew, F et al; Tridente, A (ISARIC Investigator). (2024). **Large-scale phenotyping of patients with long COVID post-hospitalization reveals mechanistic subtypes of disease**. *Nature Immunology*. 25, pp.607-621. [Online]. Available at: https://doi.org/10.1038/s41590-024-01778-0 [Accessed 18 April 2024]	Research article	Medical and Dental	N/A
Lightburn, Thomas; Yasin, Usmahn; Et al. (2025). **Suture choice when securing central lines: an update in the light of NICE surgical guidance.** *Anaesthesia*. Pre-Publication [Online]. Available at: 10.1111/anae.16588 [Accessed 6 March 2025].	Letters/comments/editorials/book reviews	Medical and Dental	7.5
Lloyd, M.; Lea, N.; Zaman, F; Bennett, N. (2024). **An evaluation of a simulation-based training programme to support final-year medical students in their preparation for foundation-year prescribing practice.** *International Journal of Pharmacy Practice.* 32(Supp. 1), p.i61. [Online]. Available at: https://doi.org/10.1093/ijpp/riae013.077 [Accessed 28 May 2024].	Research article	Medical and Dental	1.8
Lohiya, N; Iyengar, KP et al. (2024). **Assessing the current role of AP and Bernageau view radiographs in measurement of glenoid bone loss in patients with recurrent shoulder dislocation: correlation with computed tomography, magnetic resonance imaging, and arthroscopy**. *Skeletal Radiology*. Pub online 12 Sep [Online]. Available at: https://doi.org/10.1007/s00256-024-04797-y [Accessed 19 September 2024]	Research article	Medical and Dental	1.9
Lyon, M et al (Graham, D.; Abernethy, V.E.; Clewes, A.R.; Dawson, J.K. - Study Collaborators). (2024). **The influence of deprivation in the outcomes of psoriatic arthritis within the UK—utilizing Outcomes of Treatment in Psoriatic Arthritis Study Syndicate (OUTPASS) data.** *Rheumatology Advances in Practice.* 8(2) [Online]. Available at: https://doi.org/10.1093/rap/rkae051 [Accessed 28 May 2024].	Research article	Medical and Dental	3.1
Macfarlane, K; Ewart, R; Chilukuri, L; Et al. (2024). 6592 **Home oxygen for bronchopulmonary dysplasia – Are we safely discharging?** *Archives of Disease in Childhood.* 109(A), pp.203-204. [Online]. Available at: https://dx.doi.org/10.1136/archdischild-2024-rcpch.311 [Accessed 5 September 2024].	Conference abstracts/posters	Medical and Dental	4.3
Maducolil, Jeremy E; Et al. (2024). **Risk of tumour seeding in patients with liver lesions undergoing biopsy with or without concurrent ablation: meta-analysis**. *BJS Open*. 8(3),	Research article	Medical and Dental	3.2

Reference	Article Type	Professional Group	1-Year Impact
p.4. [Online]. Available at: http://dx.doi.org/10.1093/bjsopen/zra [Accessed 22 May 2024].			
Mahumud, Rashidul Alam; Pritchard Jones, Rowan; Et al. (2025). **Economic Evaluation of Inguinal Versus Ilio-inguinal Lymphadenectomy for Patients with Stage III Metastatic Melanoma to Groin Lymph Nodes: Evidence from the EAGLE FM Randomized Trial.** *Annals of Surgical Oncology.* Pre-Publication(.), p... [Online]. Available at: doi.org/10.1245/s10434-025-17040-2 [Accessed 6 March 2025].	Research article	Medical and Dental	3.4
Mangwani, Lever, C; Bansod, V; Iyengar, K; Wadood, A; McMillan, L; J; Toh, et al. (2024). **UK Foot and Ankle Thromboembolism (UK-FATE).** *The bone & joint journal*. 106(11), pp.1249-1256. [Online]. Available at: http://dx.doi.org/10.1302/0301-620X.106B11.BJJ-2024-0128.R1 [Accessed 7 November 2024].	Research article	Medical and Dental	4.9
Mariguddi, S. (2024). **6653 Embedding paediatric inequalities thinking and practice in a paediatric department – journey from a lone warrior to community of practice to improve outcomes.** *Archives of Disease in Childhood.* 109(A), pp.86-87. [Online]. Available at: https://dx.doi.org/10.1136/archdischild-2024-rcpch.122 [Accessed 5 September 2024].	Conference abstracts/posters	Medical and Dental	4.3
Martens, R; Hunter-Smith, A; Et al. (2024). **Use and impact of virtual resources for peer support by young adults living with cancer: A systematic review.** *Canadian Oncology Nursing Journal*. 34(3), pp.381-403. [Online]. Available at: 10.5737/23688076343381 [Accessed 14 August 2024].	Research article	Medical and Dental	N/A
Mettu, S.; Iyengar, K.P. et al. (2024). **Imaging in shoulder arthroplasty: Current applications and future perspectives.** *Journal of Clinical Orthopaedics and Trauma.* 53 [Online]. Available at: https://doi.org/10.1016/j.jcot.2024.102472 [Accessed 10 July 2024].	Research article	Medical and Dental	3.2
Mettu, S; Iyengar, KP et al. (2024). **Anatomy and pathology of adductor canal (Hunter's canal)**. *Skeletal Radiology*. Pub Online 13 Oct. [Online]. Available at: https://doi.org/10.1007/s00256-024-04814-0 [Accessed 17 October 2024]	Research article	Medical and Dental	1.9
Mettu, S; Iyengar, KP et al. (2024). **Calcific Enthesitis of Lateral Patellofemoral Ligament: A Rare Cause of Anterolateral Knee Pain**. *Indian Journal of Radiology and Imagin*g. Pub online 19 Nov. [Online]. Available at: https://doi.org/10.1055/s-0044-1793807 [Accessed 11 December 2024]	Research article	Medical and Dental	0.9

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Mishra, N; Iyengar, KP et al. (2025). **Exploring the quadrilateral space: Clinical anatomy, pathology, and imaging insights.** *Clinical Imaging.* Epub ahead of print (Mar 18). [Online]. Available at: https://www.clinicalimaging.org/article/S0899-7071(25)00060-9/abstract [Accessed 25 March 2025].	Research article	Medical and Dental	1.8
Mohan, R; Unnikrishnan, N; Gudena, R. (2024). **Cantilever Failure of Modular Uncemented Femoral Revision Stem in Patients with Poor Proximal Femoral Support; How to avoid it?** *Archives of Bone and Joint Surgery*. 12(4), pp.240-244. [Online]. Available at: https://abjs.mums.ac.ir/article_23868.html [Accessed 17 May 2024]	Research article	Medical and Dental	1.3
Morgan, G; Mukhtar, K et al. (2024). **OP070 Greenhouse emissions associated with general or regional anaesthesia for open reduction and internal fixation of distal radius fractures**. *Regional Anesthesia & Pain Medicine*. 49(Suppl 1), pp.A54 - A55. [Online]. Available at: https://doi.org/10.1136/rapm-2024-ESRA.69 [Accessed 12 December 2024]	Conference abstracts/posters	Medical and Dental	5.1
Morrison, E; Low SE et al. (2025). **A unique case of reactive perforating collagenosis secondary to upadacitinib treatment in severe atopic eczema.** *Clinical and experimental dermatology.* llaf122(Online ahead of print) [Online]. Available at: https://academic.oup.com/ced/advance-article-abstract/doi/10.1093/ced/llaf122/8075112?redirectedFrom [Accessed 19 March 2025].	Research article	Medical and Dental	3.7
Moussa, A; Meah, N; Et al. (2024). **Low-dose oral minoxidil improves hair length and global hair density in short anagen syndrome.** *Journal of the American Academy of Dermatology*. [Online]. Available at: https://doi.org/10.1016/j.jaad.2024.03.040 [Accessed 25 April 2024].	Research article	Medical and Dental	13.8
Mumtaz, A; Otey, N; Et al. (2024). **Breast cancer in pregnancy: a comprehensive review of diagnosis, management, and outcomes.** *Translational Breast Cancer Research*. 5. [Online]. Available at: https://dx.doi.org/10.21037/tbcr-24-26 [Accessed 5 September 2024].	Research article	Medical and Dental	N/A
Myatt, D; Ankers, T; Et al. (2024). **Are relative contraindications for unicompartmental knee replacements in medial compartment osteoarthritis really contraindications?** *Journal of Orthopaedics*. 56, pp.123 - 126. [Online]. Available at: https://dx.doi.org/10.1016/j.jor.2024.05.014 [Accessed 7 June 2024].	Research article	Medical and Dental	2.5

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Nallathamby, K; Moss, K et al. (2024). Eosinophilic Dermatosis of Haematological Malignancy. Clinical and Experimental Dermatology. Pub online 25 Oct, p.llae469. [Online]. Available at: https://doi.org/10.1093/ced/llae469 [Accessed 31 October 2024]	Letters/comments/editorials/book reviews	Medical and Dental	3.7
Nallathamby, K; Moss, K; Et al. (2024). **P010 Eosinophilic dermatosis of haematological malignancy mimicking insect bite-like reaction in a patient with chronic lymphocytic leukaemia: a case report.** *British Journal of Dermatology.* 191(Sup 1), p.i19. [Online]. Available at: https://doi.org/10.1093/bjd/ljae090.037 [Accessed 14 August 2024].	Conference abstracts/posters	Medical and Dental	11
Nandolia, K; Iyengar, KP et al. (2025). **Spine Trauma Classifications: Historical, Current, and Emerging Perspectives for Radiologists.** *Indian Journal of Radiology and Imaging.* eFirst. [Online]. Available at: https://www.thieme-connect.com/products/ejournals/abstract/10.1055/s-0045-1805025#info [Accessed 19 March 2025].	Research article	Medical and Dental	0.9
Ng, S.M; Tattersal, Z; Et al. (2025). **Omnipod5 Real-World Data from the First Pediatric Users' Universal Coverage Under the UK National Health Service.** *Diabetes technology & therapeutics.* (Ahead of Print) [Online]. Available at: http://dx.doi.org/10.1089/dia.2024.0666 [Accessed 20 February 2025].	Research article	Medical and Dental	5.7
Ng, SM. et al. (2024). **Long-term assessment of the NHS hybrid closed-loop real-world study on glycaemic outcomes, time-in-range, and quality of life in children and young people with type 1 diabetes.** *BMC Medicine.* 22. Article Number 175. [Online]. Available at: https://doi.org/10.1186/s12916-024-03396-x [Accessed 7 May 2024].	Research article	Medical and Dental	N/A
Ng, SM; Day, H; Hubbard, R; Alexopoulou, V et al. (2024). **ISPAD Annual Conference Highlights 2023**. *Hormone Research in Paediatrics*. Pub online 11 Jun(.), p... [Online]. Available at: https://doi.org/10.1159/000539749 [Accessed 31 October 2024]	Letters/comments/editorials/book reviews	Medical and Dental	2.6
Ng, SM; et al. (2023). **Internet analytics of an innovative digital educational resource of type 1 diabetes HelloType1 in local languages for people living with diabetes families and healthcare professionals in Southeast Asia**. *BMC Endocrine Disorders*. 23, p.249. [Online]. Available at: https://doi.org/10.1186/s12902-023-01501-4 [Accessed 19 April 2024]	Research article	Medical and Dental	N/A
Ng, SZ et al. (2024). **Bridging the digital divide: The UNBIASED national study to unravel the impact of ethnicity and deprivation on diabetes technology disparities in the United Kingdom**. *Diabetic Medicine*. epub 8 May. [Online]. Available at: https://doi.org/10.1111/dme.15346 [Accessed 17 May 2024]	Letters/comments/editorials/book reviews	Medical and Dental	6.9

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Ngo, V.; Rajendiran, A.; Ferrie, S.; Chadwick, M. (2024). **247 Prophylactic Use of 3D Intraperitoneal Mesh in the Prevention of Parastomal Hernia in Permanent Colostomies After Rectal Cancer Resection.** *British Journal of Surgery.* 111(Supp. 6), p.znae163.108. [Online]. Available at: https://doi.org/10.1093/bjs/znae163.108 [Accessed 29 August 2024].	Conference abstracts/posters	Medical and Dental	8.6
Nischal, N.; Iyengar, KP. et al. (2024). **Painful Ankle due to Impingement Between the Medial Malleolus and Navicular.** *Apollo Medicine.* 21(Supp.1), pp.S75-S76. [Online]. Available at: https://doi.org/10.1177/09760016241270043 [Accessed 25 October 2024].	Case studies/case series	Medical and Dental	N/A
Norris, G.; Brunskill, L.; Dickinson, K.; McClements, D. (2024). **P29 Utilising cytosponge to reduce the post-covid gastroscopy backlog.** *Gut.* 73(Suppl. 1), p.A66. [Online]. Available at: https://gut.bmj.com/content/73/Suppl_1/A66.1 [Accessed 22 October 2024].	Conference abstracts/posters	Medical and Dental	23
Nurek, M; Pydisetty, R (Collaborator) et al. (2025). **Factors influencing UK arthroplasty surgeons' decision-making between total and medial unicompartmental knee surgery: A vignette-based behavioural experiment**. *Journal of Experimental Orthopaedics*. 12(1), p.e70178. [Online]. Available at: https://doi.org/10.1002/jeo2.70178 [Accessed 11 March 2025]	Research article	Medical and Dental	3
O'Connor, C; Meah, N, et al. (2024). **A global survey to assess practice of laboratory testing in alopecia areata by hair specialists.** *British Journal of Dermatology.* 192(Sup 1), pp.i74-i75. [Online]. Available at: https://dx.doi.org/10.1093/bjd/ljae090.151 [Accessed 14 August 2024].	Conference abstracts/posters	Medical and Dental	11
O'Halloran, CP et al. (2025). **Readability of paediatric participant information leaflets in research studies**. *Paediatric Research*. Pub Online 22 Feb. [Online]. Available at: https://doi.org/10.1038/s41390-025-03943-z [Accessed 27 February 2025]	Research article	Medical and Dental	3.1
Okeke, C.J; Siddique, S; Khadr, RN; Floyd, MS Jr. (2025). **Letter to the Editor Re: Low-frequency bladder vibration for the treatment of urinary tract infections in spinal cord injury patients with neurogenic bladder by Zhang et al.** *International Urology and Nephrology.* Online ahead of print [Online]. Available at: https://link.springer.com/article/10.1007/s11255-025-04393-6 [Accessed 6 February 2025].	Letters/comments/editorials/book reviews	Medical and Dental	1.8
Okeke, CJ; et al. (2024). **Waiting Times in Prostate Cancer Diagnosis and Treatment: A Ten-Year Experience in A Nigerian Teaching Hospital**. *West African Journal of Medicine*. 41(3), pp.317-321. [Online]. Available at: https://pubmed.ncbi.nlm.nih.gov/38788158/ [Accessed 13 June 2024]	Research article	Medical and Dental	N/A

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Okoka, EM; Oyadiran, OT et al. (2024 Nov 22). **Effect of Micronutrients on HIV-Related Clinical Outcomes Among Adults Living with HIV on Antiretroviral Therapy: System.** *Nutrition Reviews.* Online ahead of print [Online]. Available at: https://academic.oup.com/nutritionreviews/advance-article-abstract/doi/10.1093/nutrit/nuae171/790715 [Accessed 3 December 2024].	Research article	Medical and Dental	5.9
Okusanya, RT; Oyadiran, OT et al. (2024). **Nutrition counselling and clinical outcomes in HIV: A systematic review and meta-analysis.** *HIV Medicine.* 25(4), pp.462-478. [Online]. Available at: https://doi.org/10.1111/hiv.13603 [Accessed 22 October 2024].	Research article	Medical and Dental	2.8
O'Leary, C.; Gardner, S. (Collaborators) Paediatric Emergency Research in the United Kingdom & Ireland (PERUKI). **Management of paediatric elbow injuries, where is the equipoise? A UK and Ireland wide international survey of practice.** *Arch Dis Child.* 2024 Sep 10:archdischild-2024-327051. doi: 10.1136/archdischild-2024-327051. Epub ahead of print. PMID: 39256006.	Letters/comments/editorials/book reviews	Medical and Dental	4.3
Othman, J; Loizou, E et al. (2024). **Outcomes with single-agent gilteritinib for relapsed or refractory FLT3-mutant AML after contemporary induction therapy**. *Blood Advances*. Pub online 12 Sep. [Online]. Available at: https://doi.org/10.1182/bloodadvances.2024014017 [Accessed 19 September 2024]	Research article	Medical and Dental	7.4
Palazzo, L; Nune, A et al. (2024). **Breakthrough SARS-CoV-2 infection in fully vaccinated patients with systemic lupus erythematosus: results from the COVID-19 Vaccination in Autoimmune Disease (COVAD) study**. *Rheumatology International*. epub 13 August [Online]. Available at: https://doi.org/10.1007/s00296-024-05682-6 [Accessed 19 August 2024].	Research article	Medical and Dental	3.2
Pannell, C; Chilukuri, L; Abdelaziz, M. (2024). **A Six-year review of deaths, a district general hospital's experience: reflection and learning.** *Archives of Disease in Childhood.* 109(A), p.400. [Online]. Available at: https://dx.doi.org/10.1136/archdischild-2024-rcpch.628 [Accessed 5 September 2024].	Conference abstracts/posters	Medical and Dental	4.3
Pellico, M.R; Nune, A; Et al. (2024). **POS1316 THE IMPACT OF MENTAL HEALTH COMORBIDITIES ON QUALITY OF LIFE IN PATIENTS WITH IDIOPATHIC INFLAMMATORY MYOPATHIES: A COVAD-2 STUDY.** *Annals of the Rheumatic Diseases*. 83(1), pp.638-640. [Online] Available at https://dx.doi.org/10.1136/annrheumdis-2024-eular.5864 [Accessed 14 August 2024].	Conference abstracts/posters	Medical and Dental	20.3
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Petrarulo, S; Paul, S; et al. (2024). **Endobronchial Ultrasound-guided Cryobiopsy of Pulmonary Artery Intimal Sarcoma.** *American journal of respiratory and critical care medicine.* [Online]. Available at: http://dx.doi.org/10.1164/rccm.202309-1633IM [Accessed 25 April 2024].	Research article	Medical and Dental	24.7
Phillips, E. (2024). **Establishing postgraduate education in urology for nurses and the non-medical workforce using a partnership model**. *British Journal of Nursing*. 33(18), pp.S28-S29. [Online]. Available at: https://www.magonlinelibrary.com/doi/abs/10.12968/bjon.2024.0352 [Accessed 17 October 2024]	Letters/comments/editorials/book reviews	Nursing and Midwifery	N/A
Pina, IM; Floyd Jr, MS. (2024). **Outcomes of Staged Urethroplasty for Distal Urethral BXO: The Whiston Hospital Experience**. *European Urology Open Science*. 67(Supplement 2), p.S14. [Online]. Available at: https://dx.doi.org/10.1016/j.euros.2024.07.027 [Accessed 2 October 2024]	Conference abstracts/posters	Medical and Dental	3.2
Pina, IM; Floyd JR, MS. (2024). **Perineal Urethrostomy**. *European Urology Open Science*. 67(Supplement 2), pp.S46-S47. [Online]. Available at: https://dx.doi.org/10.1016/j.euros.2024.07.101 [Accessed 2 October 2024]	Conference abstracts/posters	Medical and Dental	3.2
Pina, IM; Omar, AM; Floyd Jr, MS. (2024). **Medical photography and the reconstructive urologist: A 6-month prospective study**. *Urologia Journal*. epub 23 April. [Online]. Available at: https://doi.org/10.1177/03915603241241183 [Accessed 3 May 2024]	Research article	Medical and Dental	0.8
Pinnington, M; Westwood, A. (2024). **Introducing the pause after the death of a patient in critical care**. *Nursing Times*. 120(3), pp.30-31. [Online]. Available at: https://www.nursingtimes.net/clinical-archive/critical-care/introducing-the-pause-after-the-death-of [Accessed 19 April 2024]	Case studies/Case series	Nursing and Midwifery	N/A
Prada, C; Ross, M. (2024). **Spontaneous pneumomediastinum and surgical emphysema presenting as rhinolalia following ecstasy ingestion: a case report.** *Journal of Medical Case Reports.* 18(1), p.306. [Online]. Available at: http://dx.doi.org/10.1186/s13256-024-04618-9 [Accessed 4 July 2024].	Case studies/case series	Medical and Dental	1

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Puthur, SJ; Shahrokhi, N et al. (2024). **Predictors of post-operative complications following immediate implant-based breast reconstruction - a single centre experience**. *European Journal of Surgical Oncology*. 50(Suppl 1), Article Number: 108181. [Online]. Available at: https://doi.org/10.1016/j.ejso.2024.108181 [Accessed 17 May 2024]	Conference abstracts/posters	Medical and Dental	3.8
Quinn M.; Padi D.; Day H.; Hubbard R.; Finnigan L.; Rowe L.; Kyprios H.; Unsworth L.; Pintus D.; McCaffrey L.; Bray D.; Ng S.M. (2024). **Navigating dual challenges: a qualitative study of adolescents and caregivers perceptions in managing type 1 diabetes and neurodiversity.** *Hormone Research in Paediatrics*. p.1. [Online]. Available at: https://dx.doi.org/10.1159/000541195 [Accessed 19 December 2024].	Conference abstracts/posters	Medical and Dental	2.6
Raj, DRS; Nallathamby, K; Hristova, M et al. (2024). **A Systematic Review of the Learning Curves of Novices and Trainees to Achieve Proficiency in Laparoscopic Skills: Virtual Reality Simulator Versus Box Trainer**. *Cureus*. 16(11), p.e72923. [Online]. Available at: https://doi.org/10.7759/cureus.72923 [Accessed 11 December 2024]	Research article	Medical and Dental	1.1
Rajkumar, D; Ramachandran, S; Redfern, S; Kandasamy, S; Chilukuri. L; Prasad, A. (2024). **P228 Multicentre review of lung microbiome for patients with cystic fibrosis treated with elexacaftor/tezacaftor/ivacaftor**. *Journal of Cystic Fibrosi*s. 23(Suppl 1), p.S139. [Online]. Available at: https://doi.org/10.1016/S1569-1993(24)00532-0 [Accessed 12 June 2024]	Conference abstracts/posters	Medical and Dental	5.2
Rakha, EA.; Chagla, L. et al. (2024). **Revisiting surgical margins for invasive breast cancer patients treated with breast conservation therapy - Evidence for adopting a 1 mm negative width.** *European Journal of Surgical Oncology.* 50(10), p.108573. [Online]. Available at: https://doi.org/10.1016/j.ejso.2024.108573 [Accessed 12 September 2024].	Research article	Medical and Dental	3.8
Rani, PK.; Ravindrane, R. et al. (2024). **Teleophthalmology at a primary and tertiary eye care network from India: environmental and economic impact.** *Eye (London, England).* 38(11), pp.2203-2208. [Online]. Available at: https://doi.org/10.1038/s41433-024-02934-4 [Accessed 30 July 2024].	Research article	Medical and Dental	2.8
Rauf, A; Shkoukani, Z; Omar, AM; Floyd Jr; MS. (2024). **Use of a Dedicated Questionnaire to Assess Buccal Mucosal Graft Morbidity in Urethral Reconstruction**. *European Urology Open Science*. 67(Supplement 2), pp.S36-S37. [Online]. Available at: https://doi.org/10.1016/j.euros.2024.07.078 [Accessed 2 October 2024]	Conference abstracts/posters	Medical and Dental	3.2

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Raza, F.A; Altaf R; Et al. (2024). **Effect of GLP-1 receptor agonists on weight and cardiovascular outcomes: A review.** *Medicine*. 103(44), p.e40364. [Online]. Available at: doi.org/10.1097/MD.0000000000040364 [Accessed 8 November 2024].	Research article	Medical and Dental	1.4
Robinson, AS; Shkoukani, ZW; Khadr, R; Stevenson, J; Abdulmajed, MI. (2024). **A Rare Case of Scrotal Swelling: Prostate Cancer Metastasis Masquerading as a Complicated Hydrocele**. *Cureus*. 16(11), p.e74773. [Online]. Available at: https://doi.org/10.7759/cureus.74773 [Accessed 2 January 2025]	Case studies/case series	Medical and Dental	1.1
Rook, D; Temple, R et al. (2024). **Tales from the community menopause clinic**. *Post Reproductive Health*. pub online 18 Sep. [Online]. Available at: https://doi.org/10.1177/20533691241285637 [Accessed 2 October 2024]	Research article	Medical and Dental	2.5
Rowland, A. (2024). **Clarity in the law is needed to stop physical punishment of children.** *BMJ.* 385(q943). [Online]. Available at: https://doi.org/10.1136/bmj.q943 [Accessed 7 May 2024].	Letters/comments/editorials/book reviews	Medical and Dental	93.7
Russell, NH; Gharib, M (Collaborator), Nicholson, T (Collaborator) et al. (2024). **Fludarabine, Cytarabine, Granulocyte Colony-Stimulating Factor, and Idarubicin with Gemtuzumab Ozogamicin Improves Event-Free Survival in Younger Patients with Newly Diagnosed AML and Overall Survival in Patients with NPM1 and FLT3 Mutations**. *Journal of Clinical Oncology*. 42(10). [Online]. Available at: https://doi.org/10.1200/JCO.23.00943 [Accessed 17 May 2024]	Research article	Medical and Dental	45.3
Saad, A; Iyengar, KP; et al. (2024). **Exploring the potential of ChatGPT in the peer review process: An observational study**. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*. 18(2), p.102946. [Online]. Available at: https://doi.org/10.1016/j.dsx.2024.102946 [Accessed 19 April 2024]	Research article	Medical and Dental	10
Saini, R; Iyengar, K.P; Et al. (2024). **Advancing orthopaedic trauma care through WhatsApp: An analysis of clinical and non-clinical applications, challenges, and future directions.** *World Journal of Orthopedics.* 15(6), pp.529-538. [Online]. Available at: 10.5312/wjo.v15.i6.529 [Accessed 4 July 2024].	Research article	Medical and Dental	1.9
Sajjad, S.G.; Et al. (2024). **Impact of SARS-CoV-2 on male reproductive system and fertility.** *Middle East Fertility Society Journal*. 35. [Online]. Available at: https://dx.doi.org/10.1186/s43043-024-00194-6 [Accessed 18 July 2024].	Research article	Medical and Dental	1.5
Santoro, G; Alfred J; Et al. (2024). **Revisional bariatric surgery following sleeve gastrectomy: a meta-analysis comparing Roux-en-Y gastric bypass and one anastomosis gastric bypass.** *The Annals of The Royal College of Surgeons of England.*	Research article	Medical and Dental	

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Saran, S; Iyengar, K.P; Et al. (2024). **Optimizing scapulothoracic injections: the role of hand positioning in enhancing procedural ease.** *Journal of Ultrasound.* [Online]. Available at: https://doi.org/10.1007/s40477-024-00947-z [Accessed 5 September 2024].	Research article	Medical and Dental	1.3
Saran, S; Iyengar, KP et al. (2024). **Supraspinous Fossa: Anatomy and Pathology**. Indian Journal of Radiology and Imaging. epub 06 June. [Online]. Available at: https://www.thieme-connect.de/products/ejournals/abstract/10.1055/s-0044-1787667 [Accessed 28 June 2024]	Research article	Medical and Dental	0.6
Saran, S; Iyengar, KP et al. (2024). **Unveiling the spiral groove: a journey through clinical anatomy, pathology, and imaging**. *Clinical Radiology*. Pub online 12 August. [Online]. Available at: https://doi.org/10.1016/j.crad.2024.08.010 [Accessed 19 September 2024]	Research article	Medical and Dental	2.1
Saran, S; Iyengar, KP et al. (2025). **Unveiling Guyon's Canal: Insights into Clinical Anatomy, Pathology, and Imaging.** *Diagnostics (Basel).* 15(5), p.592. [Online]. Available at: https://www.mdpi.com/2075-4418/15/5/592/xml [Accessed 19 March 2025].	Research article	Medical and Dental	3
Sathanantham, K; Hickey, S; Ellison, J. (2024). **BT16 BT17 Dermatology advice and guidance: a service evaluation.** *British Journal of Dermatology.* 191(Sup 1), p.i196. [Online]. Available at: https://doi.org/10.1093/bjd/ljae090.414 [Accessed 14 August 2024].	Research article	Medical and Dental	11
Shah, K; Fang, L et al. (2024). **CO184 Reducing the Environmental Impact of Anesthetic Gases in England Without Worsening Clinical Outcomes for Patients or Increasing Resource Use**. *Value in Health*. 27(12 Suppl), p.S49. [Online]. Available at: https://doi.org/10.1016/j.jval.2024.10.260 [Accessed 2 January 2025]	Conference abstracts/posters	Medical and Dental	4.9
Shahidianakbar, M; Bickley, E; Chahwala, P; Et al. (2024). **Multiple transfusion request audit.** *Clinical Medicine.* 34(Sup 1), p.1. [Online]. Available at: https://dx.doi.org/10.1016/j.clinme.2024.100168 [Accessed 25 July 2024].	Research article	Medical and Dental	3.6

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Sharma, S; Meah, N; Et al. (2024). (P087) **The British Hair and Nail Society present a review of our national grand round of challenging hair disorders and the benefits to the wider British Association of Dermatologists membership.** *British Journal of Dermatology*. 192(Sup 1), p.i73. [Online]. Available at: https://dx.doi.org/10.1093/bjd/ljae090.148 [Accessed 14 August 2024].	Conference abstracts/posters	Medical and Dental	11
Sharma, S; Rana, A et al. (2024). **Irreducible Complex Posterior Elbow Dislocation with Varus Posteromedial Rotary Instability – A Case Report**. *Journal of Orthopedic Case Reports*. 14(6), pp.56-62. [Online]. Available at: https://doi.org/10.13107%2Fjocr.2024.v14.i06.4502 [Accessed 28 June 2024]	Case studies/case series	Medical and Dental	N/A
Sharma, S; Rana, A; Et al. (2024). **Open reduction of irreducible elbow dislocations due to varus posteromedial rotary instability may require addressing capsular interposition, ligament repair, and coronoid fixation for optimal outcome.** *Journal of Orthopedic Case Reports*. 14(6), pp.56-62. [Online]. Available at: https://doi.org/10.13107/jocr.2024.v14.i06.4502 [Accessed 4 July 2024].	Case studies/case series	Medical and Dental	N/A
Shirodkar K; Iyengar K.P.; Et al. (2024). **GIBPS technique-a novel sequential technique of performing shoulder corticosteroid injections.** *Journal of Ultrasound.* [Online]. Available at: 10.1007/s40477-024-00931-7 [Accessed 19 July 2024].	Conference abstracts/posters	Medical and Dental	1.3
Shirodkar, K; Iyengar, KP et al. (2025). **Imaging of Peripheral Intraneural Tumors: A Comprehensive Review for Radiologists**. *Cancers*. 17(2), p.246. [Online]. Available at: https://doi.org/10.3390/cancers17020246 [Accessed 29 January 2025]	Research article	Medical and Dental	4
Shirodkar, K; Iyengar, KP; et al. (2024). **Right-sided meralgia paresthetica from lateral femoral cutaneous nerve neuroma**. *Journal of Ultrasound*. epub 04 Apr. [Online]. Available at: https://link.springer.com/article/10.1007/s40477-024-00883-y [Accessed 19 April 2024]	Case studies/Case series	Medical and Dental	1.3
Shirodkar, S; Iyengar, KP et al. (2024). **Lumbar offset distance: A simplified metric for evaluation of the lumbar spine alignment**. *Journal of Craniovertebral Junction & Spine*. 15(3), pp.280-283. [Online]. Available at: https://dx.doi.org/10.4103/jcvjs.jcvjs_40_24 [Accessed 2 October 2024]	Research article	Medical and Dental	1.4
Shkoukani, Z; Chamsin, A; Abdulmajed, MI. (2024). **Metastatic Adenocarcinoma of the Prostate Masquerading as a Splenic Flexure Colonic Polyp: A Diagnostic Conundrum**. *Cureus*. 16(7), p.e64959. [Online]. Available at: 10.7759/cureus.64959 [Accessed 23 August 2024]	Case studies/Case series	Medical and Dental	1.1

Reference	Article Type	Professional Group	1-Year Impact
Siddiqui, A.; Zafar, N. et al. (2025). **An Audit Cycle of Gynecological History Documentation in Emergency Surgical Admissions of Female Patients of Childbearing Age Presenting with Acute Abdominal Pain at a District General Hospital.** *Cureus.* 17(1), p.e76945. [Online]. Available at: https://www.cureus.com/articles/328853-an-audit-cycle-of-gynecological-history-documentation-in-emer [Accessed 15 January 2025].	Research article	Medical and Dental	1.1
Siddiqui, Asher; Nowera, Zafar; Et al. (2024). **Beyond the Usual Suspects: Appendiceal Bleeding as the Surprising Cause of Lower Gastrointestinal (GI) Bleeding.** *Cureus*. 16(12), p.e76663. [Online]. Available at: http://dx.doi.org/10.7759/cureus.76663 [Accessed 9 January 2025].	Research article	Medical and Dental	1.1
Simoni, AH.; Abdul-Rahim, AH. et al. (2024). **Social determinants of health and clinical outcomes among patients with atrial fibrillation: evidence from a global federated health research network.** *QJM : An International Journal of Medicine*. 117(5), pp.353-359. [Online]. Available at: https://doi.org/10.1093/qjmed/hcad275 [Accessed 18 June 2024].	Research article	Medical and Dental	13.3
Sohail, M; Iqbal, A et al. (2024). **An Algorithmic Approach to use Extended Spreader Grafts in Deviated Noses.** *Aesthetic Plastic Surgery.* Online Ahead of Print [Online]. Available at: https://link.springer.com/article/10.1007/s00266-024-04528-7 [Accessed 3 December 2024].	Research article	Medical and Dental	2
Srinivasan. P; Pullagura, M; Selvarajan, RM; Patel, S; Ganapathy, R. (2024). **Uncommon Expression of Osteochondroma in the Wrist: A Case Report**. *Journal of Orthopedic Case Reports*. 14(8), pp.121-124. [Online]. Available at: https://doi.org/10.13107/jocr.2024.v14.i08.4670 [Accessed 23 August 2024]	Case studies/Case series	Medical and Dental	N/A
Stedman, M.; Green, L. et al. (2024). **The Impact of Age and Sex on Fasting Plasma Glucose and Glycated Haemoglobin (HbA1c) in the Non-diabetes Population.** *Diabetes Therapy.* Online ahead of print. (Dec 20). [Online]. Available at: https://link.springer.com/article/10.1007/s13300-024-01680-w [Accessed 30 December 2024].	Research article	Medical and Dental	2.8
Steinhorst, J.; Baker, C. et al. (2025). **Developing and applying a training needs analysis tool for healthcare workers managing snakebite envenoming: A cross-sectional study in Eswatini.** *PLoS neglected tropical diseases.* 19(1), p.e0012778. [Online]. Available at: https://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0012778 [Accessed 15 January 2025].	Research article	Medical and Dental	N/A

Reference	Article Type	Professional Group	1-Year Impact
Sulaiman, S K; Makama, B T. (2024). **Depression mediates the relationship between exposure to stigma and medication adherence among people living with HIV in low-resource setting: a structural equation modeling approach.** *Journal of Behavioral Medicine.* [Online]. Available at: https://link.springer.com/article/10.1007/s10865-024-00488-0 [Accessed 25 April 2024].	Research article	Medical and Dental	3.1
Tang, J; Habib, F; Rahmdil, F; Apostolou, N. (2024). **Autologous faecal microbiota transplantation via double barrel stoma to treat chronic diversion colitis.** *BMJ Case Reports.* 17(11) [Online]. Available at: https://casereports.bmj.com/content/17/11/e262806.long [Accessed 3 December 2024].	Case studies/Case series	Medical and Dental	0.6
Tennuci, Hanumanthu, G et al. (2024). **EP058 Sonoclub North West – Improving the provision of regional anaesthesia skills of trainee anaesthetists**. *Regional Anesthesia & Pain Medicine*. 49(Suppl 1), p.A104. [Online]. Available at: https://doi.org/10.1136/rapm-2024-ESRA.131 [Accessed 11 December 2024]	Conference abstracts/posters	Medical and Dental	5.1
Thompson, A. et al. (2024). **P-134 Virtual vigilance: palliative virtual ward to avoid unneeded admissions and ensure timely escalation.** *BMJ Supportive and Palliative Care.* 14(Suppl. 4), pp.A60-61. [Online]. Available at: https://doi.org/10.1136/spcare-2024-HUNC.152 [Accessed 5 February 2025].	Conference abstracts/posters	Nursing and Midwifery	2
Umutoni, A; Edeh, E et al. (2024). **Assessing the Reliability of YouTube Content for Plastic Surgery Patient Information in Africa with the Modified DISCERN and JAMA Scores**. *Annals of Plastic Surgery*. Pub online 18 Dec. [Online]. Available at: https://doi.org/10.1097/sap.0000000000004186 [Accessed 2 January 2025]	Research article	Medical and Dental	1.5
Unsworth L.; Quinn M.; Kyprios H.; Rowe L.; Hubbard R.; Finnegan L.; Murphy C.; Pintus D.; McCaffrey L.; Padi D.; Bray D.; Saunders S.; Ng S.M. (2024). **Transition readiness interventions improve some diabetes outcomes and engagement of young people following transition to adult services: an NHS England transition pilot.** *Hormone Research in Paediatrics*. 97(Suppl. 2). [Online]. Available at: https://dx.doi.org/10.1159/000541195 [Accessed 20 February 2025].	Conference abstracts/posters	Medical and Dental	2.6
Vaisha, R.; Iyengar, KP. et al. (2024). **Recurrent fractures in a teen with osteopetrosis**. *BMJ Case Reports*. 17(7), p.-. [Online]. Available at: https://doi.org/10.1136/bcr-2024-260383 [Accessed 30 July 2024].	Case studies/Case series	Medical and Dental	0.6

Reference	Article Type	Professional Group	1-Year Impact
Vaishya, R; Iyengar, K P; Et al. (2024). **Effectiveness of AI-powered Chatbots in responding to orthopaedic postgraduate exam questions-an observational study.** *International Orthopaedics.* (SICOT). [Online]. Available at: https://doi.org/10.1007/s00264-024-06182-9 [Accessed 25 April 2024].	Research article	Medical and Dental	2.7
van Akkooi, ACJ; Brackley, P et al. (2024). **1076O Primary analysis of the EORTC 1208 Minitub trial: Prospective registry of sentinel node (SN) positive melanoma patients with minimal SN tumor burden**. *Annals of Oncology*. 35(Supplement 2), p.S712. [Online]. Available at: https://doi.org/10.1016/j.annonc.2024.08.1144 [Accessed 2 October 2024]	Conference abstracts/posters	Medical and Dental	56.7
Viswanathan, VK; Iyengar, KP et al. (2024). **Chatbots and Their Applications in Medical Fields: Current Status and Future Trends: A Scoping Review.** *Apollo Medicine.* 21(4), pp.609-620. [Online]. Available at: https://journals.sagepub.com/doi/10.1177/09760016241259851 [Accessed 3 December 2024].	Research article	Medical and Dental	N/A
Viswanathan, VK; Iyengar, KP et al. (2024). **Intraosseous regional antibiotic prophylaxis in total joint arthroplasty (TJA): Systematic review and meta-analysis**. *Journal of Clinical Orthopaedics and Trauma*. 57(Pub Online 03 Oct), p.102553. [Online]. Available at: https://doi.org/10.1016/j.jcot.2024.102553 [Accessed 17 October 2024	Research article	Medical and Dental	3.2
Viswanathan, VK; Iyengar, KP et al. (2025). **Strategies for preventing anterior cruciate ligament injuries in athletes: Insights from a scoping review**. *Journal of Orthopaedics*. 67, pp.101-110. [Online]. Available at: https://doi.org/10.1016/j.jor.2025.01.001 [Accessed 29 January 2025]	Research article	Medical and Dental	3.5
Viswanathan, VK; Iyengar, KP. (2025). **Trends of publications on primary sarcomas of bone: A bibliometric analysis**. *Journal of Clinical Orthopaedics and Trauma*. 63, p.102917. [Online]. Available at: https://doi.org/10.1016/j.jcot.2025.102917 [Accessed 29 January 2025]	Research article	Medical and Dental	3.2
Westall, SJ; Watmough, S; Narayanan, RP; Irving, G; Furlong, NJ; Lewis, GA; Hardy, KJ. (2023). **1056-P: Impact of Individualized HbA1c Target Setting on Diabetes-Distress, Self-Efficacy, Well-Being, and HbA1c**. *Diabetes*. 72(Suppl 1). [Online]. Available at: https://doi.org/10.2337/db23-1056-P [Accessed 18 July 2024]	Conference abstracts/posters	Medical and Dental	6.2
White, B; Ng, SM; et al. (2024). **A practical evidence-based approach to management of type 2 diabetes in children and young people (CYP): UK consensus**. *BMC Medicine*. 22. Article Number 144. [Online]. Available at: https://doi.org/10.1186/s12916-024-03349-4 [Accessed 19 April 2024]	Research article	Medical and Dental	N/A

Reference	Article Type	Professional Group	1-Year Impact
Williams, T.C. et al. (Collaborators: Gardner, S; O'Leary, C.; Bowness, K; Morrison, M). (2025). **Maternal views on RSV vaccination during the first season of implementation in England and Scotland.** *The Lancet Infectious Diseases.* Online first (January 29, 2025) [Online]. Available at: https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(25)00060-X/fulltext#app-1 [Accessed 6 February 2025].	Letters/comments/editorials/book reviews	Medical and Dental	36.4
Willis, J. (2025). **Journal Club**. *Thorax*. 80(2), p.122. [Online]. Available at: https://doi.org/10.1136/thorax-2024-222888 [Accessed 29 January 2025]	Research article	Medical and Dental	10.8
Yang, Z; Ditchfield, C et al. (2024). **Prognostic effects of glycaemic variability on diastolic heart failure and type 2 diabetes mellitus: insights and 1-year.** *Diabetology & Metabolic Syndrome.* 16(1), p.280. [Online]. Available at: https://dmsjournal.biomedcentral.com/articles/10.1186/s13098-024-01534-2 [Accessed 3 December 2024].	Research article	Nursing and Midwifery	3.4
Zayed, H; Lechareas, S; Et al. (2024). **Transcatheter arterialization of the deep veins: 1-year outcomes of PROMISE-UK study**. *British Journal of Surgery*. 11(7), p.4. [Online]. Available at: 10.1093/bjs/znae188 [Accessed 2 August 2024].	Research article	Medical and Dental	8.6
Ziade, N; Nune, A et al. (2024). **Global disparities in the treatment of idiopathic inflammatory myopathies: results from an international online survey study.** *Rheumatology (Oxford).* 63(3), pp.657-664. [Online]. Available at: https://academic.oup.com/rheumatology/article-abstract/63/3/657/7179788?redirectedFrom=fulltext [Accessed 3 December 2024].	Research article	Medical and Dental	4.7

Title of Meeting	**Trust Board**			**Date**	26 November 2025
Agenda Item	**TB25/093 (13.2)**				
Report Title	Research and Development Operational Capability Statement (RDOCS)				
Executive Lead	Simon Dowson, Chief Medical Officer				
Presenting Officer	Simon Dowson, Chief Medical Officer				
Action Required	X	**To Approve**		**To Note**	

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

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

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

Quality and/or Equality Impact
Not applicable

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

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

NIHR Guideline B01
RDI Operational Capability Statement

All the people with research interests have confirmed they are happy for their contact details to be published

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

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
Statement 001					
Statement 002	01/11/2013	01/11/2014	27/11/2013	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 003	18/11/2014	18/11/2015	18/11/2014	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 004	31/12/2015	31/12/2016	27/01/2016	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 005			12/01/2017	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 006	01/12/2017	01/12/2018	29/11/2017	Trust Board	Mrs Jeanette Anders
Statement 007	01/12/2018	01/12/2019	28/11/2018	Trust Board	Mrs Jeanette Anders
Statement 008	01/12/2019	01/12/2020	27/11/2019	Trust Board	Mrs Jeanette Anders
Statement 009	01/12/2020	01/12/2021	25/11/2020	Trust Board	Mrs Jeanette Anders
Statement 010	01/12/2021	01/12/2022	24/11/2021	Trust Board	Mrs Jeanette Anders
Statement 011	01/12/2022	01/12/2023	30/11/2022	Trust Board	Mrs Jeanette Anders
Statement 012	01/12/2023	01/12/2024	29/11/2023	Trust Board	Mrs Jeanette Anders and Mrs Jill Simpson
Statement 013	01/12/2024	01/12/2025	29/01/2025	Trust Board	Mrs Jeanette Anders and Mrs Jill Simpson
Statement 014	01/12/2025	01/12/2026			

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Other information

Organisation RDI management arrangements

Information on key contacts.

Name of organisation	Mersey and West Lancashire Teaching Hospitals NHS Trust
Role:	Research Development and Innovation Executive Lead (Chief Medical Officer)
Name:	Dr Simon Dawson
Contact number:	Contact by email
Contact email	Simon.Dowson@MerseyWestLancs.nhs.uk
Role:	Clinical Director of Research - Whiston site
Name:	Professor Ascanio Tridente
Contact number:	Contact by email
Contact email	Ascanio.Tridente@merseywestlancs.nhs.uk
Role:	Clinical Director of Research - Southport/Ormskirk site
Name:	Dr Craig Rimmer
Contact number:	Contact by email
Contact email	craig.rimmer1@merseywestlancs.nhs.uk
RDI office details:	
Name:	Research Development and Innovation Department - Whiston site
Address:	The Research Hub, Whiston Hospital, Ground Floor , Yellow Zone, Warrington Road, Prescot, Merseyside, L35 5DR
Contact number:	0151 430 2334 / 1218
Contact email:	research@sthk.nhs.uk
Name:	Research Development and Innovation Department - Southport/Ormskirk site
Address:	Innovation Centre, Ormskirk District General Hospital, Wigan Road, Ormskirk, Lancashire, L39 2AZ
Contact number:	01695 656506/6419
Contact email:	soh-tr.researchsonhs@merseywestlancs.nhs.uk

Key contact details e.g. Feasibility, confirmation of capacity and capability to conduct research at MWL	
Contact 1:	
Role:	Research Development and Innovation Department Manager (RDI) - Whiston site
Name:	Jeanette Anders
Contact number:	0151 478 7850
Contact email:	jeanette.anders@sthk.nhs.uk
Contact 2:	
Role:	Research Development and Innovation Department Manager (RDI) - Southport/Ormskirk site
Name:	Jillian Simpson
Contact number:	01704 703457
Contact email:	Jillian.Simpson@MerseyWestLancs.nhs.uk
Contact 3:	
Role:	Research Development and Innovation Co-ordinator
Name:	Paula Scott
Contact number:	0151 430 1218
Contact email:	paula.scott@sthk.nhs.uk
Contact 4:	
Role:	Research Development and Innovation Co-ordinator
Name:	Julie Ditchfield
Contact number:	01695 656506
Contact email:	Julie.Ditchfield@MerseyWestLancs.nhs.uk
Contact 5:	
Role:	Research Development and Innovation Research Support Officer
Name:	Jennifer Miller
Contact number:	0151 290 4898
Contact email:	jennifer.miller4@sthk.nhs.uk

Information on staffing of the RDI office.

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

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

Trust Board		The Chief Medical Officer reports to the Trust Board.
The Chief Medical Officer reports to the Quality Committee.		The Quality Committee advises the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.
RDI Managers report to the Clinical Effectiveness Council (CEC)		The CEC Council investigates any issue that sits within its terms of reference. Its aim is to seek and receive from any department or service assurance on the maintenance and improvement of clinical effectiveness. The Council is authorised by the Quality Committee to investigate any issue that may pose a risk to Clinical Effectiveness. The Committee shall advise the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.

RDI Managers report to the Research Development & Innovation Group (RDIG)		The RDI Group reports to the Quality Committee to provide assurance about all aspects of RDIG activity within and involving the Trust. The Chair of the RDI Group is the Clinical Director for Research Development and Innovation. The RDI Group is responsible for: Review and approval of the RDI strategy consistent and compliant with contemporary (inter)national guidance Review and approval of the Annual RDI Report (written by the RDI Managers) Review and approval of the Research Capability and Capacity Statement Review and approval of the Research Standard Operating Procedures Oversee operational delivery of the RDI strategy via updates received from the RDI Managers Review of research studies deemed high risk or with identified issues/concerns will be referred to RDIG for consideration (by the RDI Managers). Any risk or safety issues relating to research activity will be reported to the RDI Group for discussion and action plan. The Core membership of the RDI Group oversees the reinvestment (in research) of the commercial and non-commercial funding and the income distribution plan.
The Research Practitioner Group (RPG)		The Research Practitioner Group (RPG) The RPG is responsible for: Review Research Standard Operating Procedures (SOPs) prior to submission to RDIG for approval. Ensure that the Trust is prepared for a Research MHRA (Medicines and Healthcare Products Regulatory Agency) inspection through the review and discussion of regular action plans Support the aim to embed a positive research culture throughout the organisation Ensure that lessons are learned from research audits/issues and that effective improvement is implemented Ensure that on a day to day basis RDI activities are conducted according to RDI Standard Operating Procedures (SOPs) Support the training programme for Research Nurses to ensure that they are fully complaint in accordance with nursing/trust requirements.

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

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

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

Organisation name	Details of collaboration / partnership (e.g. university/organisation joint office, external provider of pathology services to organisation, etc., effective dates)	Contact name	Email address	Contact number
University of Edge Hill Manchester Metropolitan University	Professor Ascanio Tridente The Trust is involved in a number of research projects with Manchester Metropolitan University, the University of Liverpool and Edge Hill University, involving collaborations, among others, with Critical care (Prof A Tridente, CD and Honorary Professor, Edge Hill University, Visiting Professor, Manchester Metropolitan University), Burns and Plastics, etc. Prof Tridente is also the Clinical Lead for Critical Care with the National Institute for Health and Care Research (NIHR) Research Delivery Network (RDN) Northwest, Editor in Chief of Acute Medicine Journal, official journal of the Society of Acute Medicine (RILA publications), Associate Editor for Scars, Burns and Healing (SAGE, London), Regional Clinical Lead (Education), Organ Donation, NHS Blood Transplant North-West, Deputy Chair of the British Burns Association, and National Co-Lead – Careers, Faculty of Intensive Care Medicine. Prof Tridente holds other roles, including being an Associate of the General Medical Council, and is author or co-author of over 80 international peer, reviewed high impact research papers and book chapters (H-index = 38)	Professor Ascanio Tridente	Ascanio.Tridente@merseywestlancs.nhs.uk	
Trainees in Emergency Medicine Research Network. (TERN)	Dr Craig Rimmer is a Consultant in Adult and Paediatric Emergency Medicine at MWL, as well as CD, CCIO and clinical lead for trauma. Dr Craig Rimmer was one of the founding members of the TERN. The Network continues to meet its aim of improving access to research opportunities and demystify clinical research in Emergency Medicine (EM). This network is supported and funded by RCEM, This approach has research opportunities for all trainees in EM, through collaborative project identification/design, followed by provision of support, guidance, training and infrastructure. The studies performed by TERN have in excess of 10,000 participants and often involve over 100 emergency departments in each study. Alongside this Dr Rimmer has been working with NHS England to look at ways of refining the process for research databases, such as Edge in order to streamline processes for all research staff across the country. In addition, Dr Rimmer has also been part of the development process for an Emergency Medicine specific GCP course which is now live.	Dr Craig Rimmer	Craig.Rimmer1@MerseyWestLancs.nhs.uk	

University of Liverpool Manchester Metropolitan University	Professor Kayvan Shokrollahi, Consultant Plastic Surgeon at MWL is an Honorary Clinical Professor at the University of Liverpool and Visiting Professor of Reconstructive Plastic Surgery at Manchester Metropolitan University He is involved in a wide range of collaborative research projects nationally and internationally with a focus of burns, scars, lasers, skin cancer, wound dressings, patient reported outcomes, medical devices, surgical techniques, and medical technology. He is Editor-in-Chief of Scars, Burns & Healing Journal [SAGE] and has published over 100 papers in peer reviewed academic journals along with four textbooks in his field.	Professor Kayvan Shokrollahi	Kayvan.Shokrollahi@merseywestlancs.nhs.uk	
University of Liverpool University of Edge Hill	Professor Rowan Pritchard Jones, Consultant Plastic Surgeon at MWL is an Honorary Clinical Professor at Edge Hill University, and an Honorary Clinical Professor at the University of Liverpool. MWL are involved in a number of research projects with Liverpool and Edge Hill University Professor Rowan Pritchard Jones is also the Medical Director of the Cheshire and Merseyside Integrated Care Board.	Professor Rowan Pritchard Jones	Rowan.PritchardJones@merseywestlancs.nhs.uk	
University of Edge Hill	Professor Greg Irving is an academic General Practitioner with a strong interest in primary care research and delivery. He currently serves as the NIHR Research Delivery Network (RDN) National Specialty Lead for General Practice and Associate Medical Director for Research within the Cheshire and Merseyside Integrated Care Board (ICB). He is also the Director of the Health Research Institute and Director of the Edge Hill Primary and Integrated Care (EPIC) Centre. Professor Irving's research focuses on the development, implementation, and evaluation of interventions designed to improve outcomes and service delivery in primary care. His methodological expertise spans systematic reviews, randomised controlled trials, observational studies, qualitative research, and	Professor Greg Irving	irvingg@edgehill.ac.uk	
University of Liverpool	Dr Andrew Hill is a consultant stroke physician at Mersey and West Lancashire Teaching Hospitals. He is an honorary associate professor of the University of Liverpool, affiliated to the Institute of Life Course and Medical Sciences, and the Liverpool Centre for Cardiovascular Sciences. His work looks at atrial fibrillation and hypertension as causes of stroke and is a co-investigator of the NIHR-funded OSSBI study, looking at the provision of eye services for patients with acquired brain injury. He is the theme lead for data and AI for the medical school. He leads a number of student-led research projects teaching students to use data and AI for medical research and practice.	Dr Andrew Hill	Andrew.Hill2@merseywestlancs.nhs.uk	
Liverpool School of Tropical Medicine	The Trust has established links with the Liverpool School of Tropical Medicine.	For details of staff interested in research at the Liverpool School of Tropical Medicine please contact the RDI Management Team	Research@merseywestlancs.nhs.uk	
St Helens Primary care	The Trust has links to Primary Care through the Marshall Cross . These links are vital and offer us the potential to collaborate on joint research projects as well as recruiting from the primary care sector.	Dr Greg Irviing GP and Consultant in Primary Care St.Helens CCG Governing Body Member	Greg.Irving3@merseywestlancs.nhs.uk	

North West Regional Research Delivery Network (NW RRDN)	MWL are a partner organisation of the North West Regional Research Delivery Network (NW RRDN)	For details please contact the RDI Management Team	Research@merseywestlancs.nhs.uk	
NIHR Applied Research Collaboration (ARC) North West Coast	MWL are a partner of the ARC NWC. The aims of the ARC NWC are to improve outcomes for patients and the public through collaboration working by bringing together academics, health and social care providers, members of the public, universities and local authorities. Its vision is to improve the quality, delivery and efficiency of health and care services; reduce health inequalities and increase the sustainability of the health and care system both locally and nationally.	Professor Mark Gaby, Director NIHR CLAHRC NWC	Gabbay, Mark <mbg@liverpool.ac.uk>	
Liverpool Health Partners	MWL have links with Liverpool Health Partners (LHP). LHP work together with Academic and NHS partners to develop groundbreaking research by encouraging conversations across the region, and sharing expertise to improve population health outcomes and economic productivity for the better.	For details please contact the RDI Management Team	research@merseywestlancs.nhs.uk or soh-tr.researchsonhs@merseywestlancs.nhs.uk	
UK Research and Innovation	MWL have links UKRI. UKRI organisation brings together the seven disciplinary research councils, Research England, which is responsible for supporting research and knowledge exchange at higher education institutions in England, and the UK's innovation agency, Innovate UK.	For details please contact the RDI Management Team	research@merseywestlancs.nhs.uk or soh-tr.researchsonhs@merseywestlancs.nhs.uk	communications@ukri.org
NIHR Research Support Service -North West	The Research Support Service in the North West is part of the NIHR infrastructure and exists to provide support and advice for people preparing NIHR grant applications.		https://www.nihr.ac.uk/support-and-services/research-support-service	
Liverpool Heart and Chest Hospital	Professor Gregory Lip is a clinical researcher and Price-Evans Chair of Cardiovascular Medicine, at the University of Liverpool. He is Director of the Liverpool Centre for Cardiovascular Science at the University of Liverpool, Liverpool John Moores University and Liverpool Heart & Chest Hospital.	Professor Greg Lip	lipgy@liverpool.ac.uk	
Clatterbridge Centre for Oncology (CCC)	MWL & CCC work collaboratively. There is an agreement in place whereby patients have access to Systemic Anti-Cancer Therapy (SACT) trials at MWL through the availability of CCC employed staff working to CCC governance arrangements.	For details please contact the Research Management Team	Research@merseywestlancs.nhs.uk	

Innovation Agency (Academic Health Science Network, North West Coast)	The Trust is a partner of the AHSN, we work together to embed innovation as a core part of the business within MWL .	For details please contact the Research Management Team	Research@merseywestlancs.nhs.uk or soh-tr.researchsonhs@merseywestlancs.nhs.uk	

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).

Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation study capabilities

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

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

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

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

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

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

Organisation services

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

Service department	Specialist facilities that may be provided (e.g. number/type of scanners)	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Designated Research Clinics located within the Research Hub at Whiston Hospital		Jeanette Anders	jeanette.anders@meseywestlancs.nhs.uk		
Pharmacy - Whiston site	Designated Research Pharmacist	Jodie Kirk	jodie.kirk@merseywestlancs.nhs.uk		
Pharmacy - Whiston site	Back up Research Pharmacist	Sophie Helsby	Sophie.Helsby@merseywestlancs.nhs.uk		
Pharmacy - Whiston site	Pharmacy Technician	Jessica Wilton	Jessica.Wilton@merseywestlancs.nhs.uk		
Pathology - Whiston and Southport sites	Minus 20, 30 and 80 freezers	Marc Seddon	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites		Generic contact	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Biochemistry	Lesley Mather Biochemistry Service Manager	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Biochemistry	Jane Turnbull Biochemistry Operational manager	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Haematology/ Transfusion	Jude Raine Haematology/Transfusion Service Manager	pathology.support@sthk.nhs.uk		
Pathology -Whiston and Southport sites	Haematology/ Transfusion	Ana Martins Haematology Operational Manager	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Microbiology	Diane MartinBiaz Microbiology Service Manager	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Generic Pathology	Marc Seddon Reception Lead Victoria Gaylor/Lucy Meadowcroft Reception Managers	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Microbiology	Neil Rathbone/Paul McMullen Microbiology Operational Managers	pathology.support@sthk.nhs.uk		
Pathology - Southport site	Generic	Mr Andrew Taylor	andy.taylor@sthk.nhs.uk		
Radiology - Whiston site	Clinical Radiation Expert	Dr Meenal Abhyankar	Meenal.abhyanker@sthk.nhs.uk		Clinical Director for Radiology
Radiology -Whiston□	Clinical Radiation Expert	Dr Andrea Howes	andrea.howes@merseywestlancs.nhs.uk		
Radiology - Whiston and St Helens sites	Medical Physics Expert	Ryan Jones	ryanjones@irs-limited.com.		Ryan Jones from IRS Ltd is one of the
Radiology - Whiston and St Helens sites	2x 1.5 GE MRI 1 x 3.0T MRI	Sue Conroy	Sue.Conroy@merseywestlancs.nhs.uk		
Radiology - St Helens site	2x Digital Mammography including tomosynthesis	Sue Conroy	Sue.Conroy@merseywestlancs.nhs.uk		
Radiology - Whiston site	1x Digital dental including cephalometry Cone Beam CT 1 x Digital	Sue Conroy	Sue.Conroy@merseywestlancs.nhs.uk		
Radiology - Whiston site – 1 Fluoro and 1 IR, St Helens 1 Fluoro	2x Fluoroscopy /1 x interventional	Sue Conroy	Sue.Conroy@merseywestlancs.nhs.uk		
Radiology - Whiston site and St H, Newton, ST WIC, WUCC, Lowe House (Obstetric only)	30X Ultrasound excluding Cardiac	Sue Conroy	Sue.Conroy@merseywestlancs.nhs.uk		
Radiology - Whiston site and St helens, Newton, St WIC, WUCC	10x Digital radiography including tomosynthesis	Sue Conroy	Sue.Conroy@merseywestlancs.nhs.uk		
Radiology - Southport/Ormskirk site	Radiology Systems Administrator	David Lodwig	david.lo@merseywestlancs.nhs.uk		

Cardio-Respiratory Department - Whiston site	Electrocardiograms: 12 lead ECGs 24 hour ambulatory electrocardiography Extended ambulatory electrocardiography Event Recording Ambulatory blood pressure monitoring Transthoracic echocardiography Transoesophageal echocardiography Stress echocardiography Exercise electrocardiography Spirometry Measurement of maximum expiratory and inspiratory flow volume loop Oximetry assessment Carbon monoxide transfer factor test Simple lung function exercise test Measurement of static lung volumes Measurement of respiratory muscle strength Measurement of maximum expiratory and inspiratory flow volume loop Bronchial Reactivity Overnight oximetry (Includes: Measurement of oxygen desaturation index FENO testing Sleep Assessments Cardio-Pulmonary Exercise testing Assessment for fitness to fly (hypoxic challenge) - flight assessment	Gina Rogers	gina.rogers@merseywestlancs.nhs.uk		

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

Department	Specialist services that may be provided	Contact name within service department	Contact email	Contact number	Details of any internal agreement
Archiving	Archiving arrangements are part of the Trust approval process and are detailed in the Clinical Trial Agreement for each study. The Trust also holds a Standard Operating Procedure for archiving.	Jennifer Miller - Whiston site Julie Ditchfield - Southport site	Jennifer.Miller4@merseywestlancs.nhs.uk Julie.ditchfield @MerseyWestLancs.nhs.uk		
Contracts (study related)	Completion and Review - See comments	Jeanette Anders and Paula Scott - Whiston Site Jill Simpson and Julie Ditchfield - Southport Site	research@@merseywestlancs.nhs.uk soh-tr.researchsonhs@merseywestlancs.nhs.uk		The model agreement for non-commercial research and commercial research is used by Mersey and West Lancashire Teaching Hospitals NHS Trust
Contracts (study related)	Sign off of clinical trial agreements	Dr Simon Dawson			The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by Mersey and West Lancashire Teaching Hospitals NHS Trust
Finance - Whiston site	Corporate Accountant	Karen Gerrard	karen.gerrard@merseywestlancs.nhs.uk		The RDI Department has links with finance and are fully supported in all areas relating to research.
Finance - Southport/Ormskirk site	Deputy Finance Business Partner - Corporate Services	Karen Gerrard	karen.gerrard@merseywestlancs.nhs.uk		The RD&I Department has links with finance and are fully supported in all areas relating to research.

Information Technology	Director of Informatics	Malcom Gandy	Malcolm.Gandy3@merseywestlancs.nhs.uk		RDI Department is fully supported by the Director of ICT. IT training, IT system set up, hardware and software configuration set up, firewall configuration and connection to external servers.
Legal - Whiston site	Head of Complaints & Legal Services	Tom Briggs	Tom.Briggs@merseywestlancs.nhs.uk		Support and advice with the legal aspects of research is provided when necessary.
HR	Research Passports, Letters of Access	Employment Services	Employment.Services@merseywestlancs.nhs.uk		
Training -- Whiston site	Essential In house Standard Operating Procedure Training	Jeanette Anders, Senior Research Nurses	research@merseywestlancs.nhs.uk		In house training on essential Standard Operating Procedures is provided for new starters or as updates if required.
Training -- Whiston site	Good Clinical Practice (GCP) training. Principal Investigator Essentials training. The RDI Manager at the Whiston site is a Facilitator for the above NIHR training courses.	Jeanette Anders	research@merseywestlancs.nhs.uk		.
Performance Management of studies - Whiston site	Audit and on-going review of studies.	Research Management Team Department	research@merseywestlancs.nhs.uk		During the RDI approval process, feasibility, capacity and capability checks take place including requirement for nurse support, appropriate resources, equipment
Performance Management of studies - Southport/Ormskirk site	Audit and on-going review of studies.	Research Management Team Department	soh-tr.researchsonhs@merseywestlancs.nhs.uk		During the RDI approval process, feasibility, capacity and capability checks take place including requirement for nurse support, appropriate resources, equipment & facilities, realistic recruitment target etc. After approval is granted, the RDI Department

Organisation RDI interests

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

Area of interest	Details	Contact name	Email	Contact number
Whiston, St Helens and Newton Hospitals				
Acute Medical Unit		Dr Thiru Desa	Thiru.Desa@sthk.nhs.uk	
Anaesthetics		Dr K Mukhtar	Karim.Mukhtar@merseywestlancs.nhs.uk	
Anaesthetics		Dr Kingston	anaesthetics@merseywestlancs.nhs.uk	
Anaesthetics	For details of other staff interested in Anaesthetic	RDI Management Team	research@merseywestlancs.nhs.uk	
Burns and Plastics		Mr P Brackley	philip.brackley@merseywestlancs.nhs.uk	
Burns and Plastics		Professor K Shokrollahi	Kayvan.Shokrollahi@merseywestlancs.nhs.uk	
Burns and Plastics	Interests - skin cancer, abdominal wall reconstruction, facial palsy, and cranial and spinal reconstruction	Mr A Benson	Alex.Benson@merseywestlancs.nhs.uk	
Burns and Plastics	For details of other staff interested in Burns and Plastics research, please contact the RDI Management Team	RDI Management Office	research@merseywestlancs.nhs.uk	
Lung Cancer (Radiology)		Dr Meenal Abhyankar	Meenal.Abhyankar@merseywestlancs.nhs.uk	
Cancer		Dr Puneet Malhotra	respiratory.secretary@nhs.net	
Cancer		Ms Leena Chagla	Breast.Secretaries@merseywestlancs.nhs.uk	
Cancer		Dr Taylor	haematologysecs_merseywestlancs.nhs.uk	
Cancer		Dr E Hindle	Dermatology.secretaries@merseywestlancs.nhs.uk	
Cancer		Mr R Pritchard-Jones	rowan.pritchardjones@merseywestlancs.nhs.uk	
Cancer		Mr P Brackley	philip.brackley@merseywestlancs.nhs.uk	
Cancer		Mr J McCabe	UrologySecretaries-DL@merseywestlancs.nhs.uk	
Cancer		Dr S Evans	haematologysecs_merseywestlancs.nhs.uk	
Cancer		Dr Raj Sripadam (CCC)	rajaram.sripadam@nhs.net	ccf-tr.breast.admin@nhs.net
Cancer		Dr S Cook	psychology@merseywestlancs.nhs.uk	
Cancer	For details of staff interested in Cancer research,	RDI Management Team	research@sthk.merseywestlancs.nhs.uk	
Cardiology		Dr R Katira	Ravish. Katira@merseywestlancs.nhs.uk	
Cardiology		Dr AlChaghouri	Samir.AlChaghouri@merseywestlans.nhs.uk	
Care of the Elderly (Urgent Community Response & Community Frailty Team)		Dr A Gatignol	lynsey.hodgson@merseywestlancs.nhs.uk	
Care of the Elderly	For details of staff interested in Care of the Elderly	RDI Management Team	research@merseywestlancs.nhs.uk	
Critical Care		Dr A Tridente	Ascanio.Tridente@merseywestlancs.nhs.uk	
Critical Care		Dr G Hanumanthu	whistoncriticalcareunit@MerseyWestLancs.nhs.uk	
Critical Care/Anaesthetics	For details of staff interested in Critical Care and	RDI Management Team	research@merseywestlancs.nhs.uk	
Dermatology		Dr Layla Hanna-Bashara	Layla.HannaBashara@merseywestlancs.nhs.uk	
Diabetes	Special interests - Diabetes Mellitus, Cardiovascular disease.	Dr N Furlong	naill.furlong@merseywestlancs.nhs.uk	
Diabetes & Endocrinology		Dr P Narayanan	Prakash.Narayanan@merseywestlancs.nhs.uk	
Diabetes		Dr S Westall	Sam.Westall@merseywestlancs.nhs.uk	
Diabetes		Dr H Sullivan	Heather.Sullivan@merseywestlancs.nhs.uk	
Emergency Medicine		Dr R Fuller	robert.fuller@merseywestlancs.nhs.uk	
Emergency Medicine		Dr M Hedley	Mike.Hedley@merseywestlancs.nhs.uk	
Emergency Medicine	For details of staff interested in Emergency Medicine research, please contact the RDI	RDI Management Team	research@merseywestlancs.nhs.uk	
ENT	For details of staff interested in ENT research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Gastro		Dr R Chandy	Rajiv.Chandy@merseywestlancs.nhs.uk	
Gastro		Dr A Bassi	ash.bassi@merseywestlancs.nhs.uk	
Gastro		Dr C Watters	gastroenterologysecr@merseywestlancs.nhs.uk	
Gastro		Dr K Clarke	Katie.Clark2@merseywestlancs.nhs.uk	
Gastro	For details of staff interested in Gastro research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Haematology		Dr T Nicholson	shk-tr.sthkhaematology@nhs.net	
Haematology		Dr David Taylor	haematologysecs_sthk@merseywestlancs.nhs.uk>	
Haematology		Dr K Moss	Kat.Moss@merseywestlancs.nhs.uk	
Hepatology	For details of staff interested in Hepatology research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	

Histopathology	For details of staff interested in Histopathology research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
General Medicine		Dr M Nasher	Magda.Nasher2@merseywestlancs.nhs.uk	
Microbiology		Dr M Vardhan	Madhur.Vardhan@merseywestlancs.nhs.uk	
Musculoskeletal		Dr J Dawson	Julie.Dawson@merseywestlancs.nhs.uk	
Musculoskeletal		Mrs D Lenton	Debbie.Lenton@merseywestlancs.nhs.uk	
Musculoskeletal	For details of staff interested in Musculoskeletal research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Nephrology and Acute Medicine	For details of staff interested in Nephrology and Acute Medicine research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Ophthalmology	For details of staff interested in Ophthalmology research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Orthopaedics		Mr Lipscombe	Stephen.Lipscombe@merseywestlancs.nhs.uk	
Orthopaedics		Mr Cartwright Terry	Matt.CartwrightTerry@merseywestlancs.nhs.uk	
Orthopaedics	For details of staff interested in Orthopaedic research, please contact the Trauma and Orthopaedic secretaries	Trauma and Orthopaedic secretaries	whis.orthosecs@sthk.nhs.uk	
Palliative Care		Dr A Thompson	Anthony.Thompson2@merseywestlancs.nhs.uk	
Pathology	Whiston and Southport sites	Mr K McLachlan	pathology.support@merseywestlancs.nhs.uk	
Pathology (cellular)	For details of staff interested in Pathology (cellular) research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Paediatrics		Dr R Garr	Rosaline.Garr@merseywestlancs.nhs.uk	
Paediatrics		Mr K Saldanha	tandosecretaries@meseywestlancs.nhs.uk	
Paediatrics		Dr L Chilukuri	lakshmi.chilukuri@merseywestlancs.nhs.uk	
Paediatrics		Dr Ijaz Ahmad	Ijaz.Ahmad@merseywestlancs.nhs.uk	
Paediatrics	For details of staff interested in Paediatric research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Parkinson's	For details of staff interested in Parkinson's research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Pharmacy		Jodie Kirk -Clinical Trials Pharmacist	jodie.kirk@merseywestlancs.nhs.uk	
Pharmacy		Sophie Helsbey	Sophie.Helsby@merseywestlancs.nhs.uk	
Pharmacy		Mr Greg Barton	greg.barton@merseywestlancs.nhs.uk	
Psychiatry		Dr C Findlay	Christopher.Findlay@shknhs.mail.onmicrosoft.com	
Psychiatry (old age)	For details of staff interested in Psychiatry (old age) research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Psychotherapy (child and adolescent)	For details of staff interested in Psychotherapy (child and adolescent) research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Radiology	For details of staff interested in Radiology research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Reproductive and Child Health	Interests - preterm and perinatal health	Ms R Agass	Ria.Agass2@merseywestlancs.nhs.uk	
Reproductive and Child Health		Ms T Safdar	Tabassum.Safdar@merseywestlancs.nhs.uk	
Reproductive and Child Health		Ms S Pankaja	Susmita.Pankaja@merseywestlancs.nhs.uk	
Reproductive and Child Health		Ms A Roberts	Anne.Roberts3@merseywestlancs.nhs.uk	
Reproductive and Child Health		Mrs Sandhya Rao	Sandhya Rao@merseywestlancs.nhs.uk	
Reproductive and Child Health	For details of staff interested in Reproductive and Child Health research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Respiratory		Dr J Marlow	Jenny.marlow@meseywestlancs.nhs.uk	
Respiratory		Dr J Heaton	Joanne.Heaton@merseywestlancs.nhs.uk	
Sexual Health		Dr Rebecca Thompson Glover	Rebecca.ThomsonGlover@sthk.nhs.uk	
Stroke		Dr S Mavinamane	sunandra.mavinamane@merseywestlancs.nhs.uk	
Stroke		Dr A Hill	andrew.hill@merseywestlancs.nhs.uk	
Stroke		Lauren Hepworth	monvjlh3@liverpool.ac.uk	

Stroke	For details of staff interested in Stroke research, please contact the RDI Management Team	RDI Management Team	research@merseywestlancs.nhs.uk	
Surgery		Mr S Kanwar	Sunjay.Kanwar@merseywestlancs.nhs.uk	
Surgery		Mr Bagade	Neeraj.Bagade@merseywestlancs.nhs.uk	
Surgery	For details of staff interested in Surgical research,	RDI Management Team	research@merseywestlancs.nhs.uk	
Urology		Mr J McCabe	john.mccabe@meseywestlancs.nhs.uk	
Urology		Mr Omar	Ahmad.Omar@merseywestlancs.nhs.uk	
Urology		Mr Samsudin	Azi.Samsudin@sthk.nhs.uk	
Southport and Ormskirk Hospitals				
Ageing	For details of staff interested in research in the ageing please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Anaesthesia, Perioperative Medicine and Pain Management	For details of staff interested in Anaesthetic Perioperative Medicine and Pain Management research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Cancer	For details of staff interested in Cancer research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Children		Dr Sudhakar Kandsamy	sudhakar.kandasamy@merseywestlancs.nhs.uk	
Children	Areas of interest include; paediatric diabetes, type	Prof May Ng	may.ng@merseywestlancs.nhs.uk	
Children	For details of other staff interested in Childrens research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Critical Care	For details of staff interested in Critical Care research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Critical Care/Anaesthesia		Dr Chris Goddard		
Dementias and Neurodegeneration		Helen Terrett	helen.terrett@merseywestlancs.nhs.uk	
Dermatology	For details of staff interested in Dermatology research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Diabetes		Prof May Ng	may.ng@merseywestlancs.nhs.uk	
Gastroenterology		Dr Michael Roberts	michael.roberts@merseywestlancs.nhs.uk	
		Dr Nikolaos Apostolou	nikolaos.apostolou@merseywestlancs.nhs.uk	
Haematology	For details of staff interested in Haematology research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Health Services Research		Dr Craig Rimmer	craig.rimmer1@merseywestlancs.nhs.uk	
Hepatology		Dr Michael Roberts	michael.roberts@merseywestlancs.nhs.uk	
Hepatology		Dr Nikolas Apostolou	nikolaos.apostolou@merseywestlancs.nhs.uk	
Infection		Dr Craig Rimmer	craig.rimmer1@merseywestlancs.nhs.uk	
Infection		Dr Stefania Pintus	stefania.pintus@merseywestlancs.nhs.uk	
Infection	For details of other staff interested in Infection research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Mental Health	For details of staff interested in Mental Heath research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Musculoskeletal Disorders		Dr Arvind Nune	arvind.nune@merseywestlancs.nhs.uk	
Musculoskeletal Disorders		Mr Shiv Sha	Janet.morton@merseywestlancs.nhs.uk	
Neurological Disorders		Helen Terrett	helen.terrett@merseywestlancs.nhs.uk	
Neurological Disorders	For details of staff interested in Neurological Disorders research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	

Radiology	For details of staff interested in Neurological Disorders research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Renal Disorders	For details of staff interested in Renal research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Reproductive Health and Childbirth		Nikos Chados	nikolaos.chados@merseywestlancs.nhs.uk	
Reproductive Health and Childbirth	For details of other staff interested in Reproductive Health and Childbirth research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Respiratory Disorders		Dr Chris McManus	Christopher.McManus@MerseyWestLancs.nhs.uk	
Rheumatology		Dr Arvind Nune	arvind.nune@merseywestlancs.nhs.uk	
Stroke		Amy Slack	amy.slack@merseywestlancs.nhs.uk	
Stroke	For details of staff interested in Stroke research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	
Spinal Cord Injuries		Vaidyanathan Subramanian	subramanian.vaidyanathan@merseywestlancs.nhs.uk	
Spinal Cord Injuries		Bakul M Soni	_bakul.soni@merseywestlancs.nhs.uk	
Trauma and Emergency Care		Dr Craig Rimmer	craig.rimmer1@merseywestlancs.nhs.uk	
Trauma and Emergency Care		Mr Eugene Toh	eugene.toh@merseywestlancs.nhs.uk	
Trauma and Emergency Care		Mr Khushroo Suraliwala	khusroo.suraliwala@merseywestlancs.nhs.uk	
Trauma and Emergency Care	For details of other staff interested in Trauma and Emergency Care research, please contact the RDI Management Team	RDI Management Team	soh-tr.researchsonhs <soh-tr.researchsonhs@merseywestlancs.nhs.uk>	

National / local	Specialty group	Specialty area (if only specific areas within group)	Contact name	Contact email	Contact number
North West RDI Managers meeting	Research	Research and Development	Jeanette Anders	jeanette.anders@merseywestlancs.nhs.uk	0151 478 7850
North West RDI Managers meeting	Research	Research and Development	Jillian Simpson	Jillian.Simpson@MerseyWestLancs.nhs.uk	01704 703457
Research Delivery infrastructure (e.g. research nurses, health care assistants, administrators)	Ad hoc requests submitted by RDI Manager to the Clinical Research Network, North West Coast for resources to enable delivery of NIHR portfolio studies.		Ad hoc		
Release of clinician time (to prepare NIHR grant applications or to act as Principal Investigators)	Ad hoc requests submitted by researchers for resources to enable delivery of both Commercial and Non-Commercial research.		Ad hoc		

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

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

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

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

Other information

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

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	26 November 2025
Agenda Item	**TB25/094**			
Report Title	NHS Oversight Framework – Provider Capability Statement Self-Assessment			
Executive Lead	Rob Cooper, Chief Executive			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To Approve**	X	**To Note**

Purpose

For the Board to note the capability self-assessment submission to NHS England.

Executive Summary

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

Trust Boards must 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

The self-assessment is intended to be used alongside the NOF segments to judge what actions or support are appropriate at each Trust.

The evidence to support the self-assessment was discussed in Strategy Board in October 2025 and submitted to NHSE 30 October 2025.

As agreed, the Trust returned five 'confirmed' statements and one 'partially confirmed' statement (Productivity and value for money).

Financial Implications

None as a direct result of this paper.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the NHS Oversight Framework – Provider Capability Statement Self-Assessment submission.

Strategic Objectives

	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways

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

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • 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	**Confirmed**	*The Trust has many system partners adding complexity to collaboration. The Trust covers two ICBs and 5 Places/Local Authority areas. The Trust is a member of the Place Boards across St Helens, Knowsley, Halton, West Lancashire and Sefton including NED representation. The Trust is a member of the provider collaborative and is working with the two ICBs and NHSE to deliver the Shaping Care Together programme to deliver sustainable healthcare services for the population of Southport, Formby and West Lancashire. The Trust is working with system partners to deliver the 2025/26 financial plan for Cheshire and Merseyside.*
Quality of care	• Having had 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), 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 • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	*MWL is now in year 3 of its post transaction integration and harmonisation journey. There have been 6 CQC inspections since the transaction, with no major concerns or enforcement actions. There is a single clinical governance structure in place, that provides assurance to the Quality Committee and Board. The Trust continues to rely on two legacy EPR systems, until a single EPR can be procured (MWL was awarded national funds to support this and is working with Warrington and Halton Hsopitals NHSFT on a joint procurement)*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	*No specific population health targets have been requested by or agreed with C&M ICB.*
Productivity and value for money	• 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	**Confirmed**	
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • 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	**Confirmed**	*There is an outstanding contractual dispute regarding the continueing funding for the Southport CDC, which has been appropriatly escalated and addressed by the Trust but not yet resolved.*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	

Signed on behalf of the board of directors

Name	Rob Cooper, Chief Executive
Date	29 October 2025