Mersey and West Lancashire Teaching Hospitals NHS Trust

Quality Account 2024-25

OUR VISION
5 star patient care

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

OUR VALUES

We are KIND

We:
- Treat every individual with respect
- Are compassionate in our support of patients and colleagues
- Are friendly and welcoming and always introduce ourselves
- Care for each other as we care for our patients
- Are polite and value each other's thoughts and ideas

We are OPEN

We:
- Are always listening and learning
- Encourage and support two-way communication
- Are honest, fair and open with others
- Take responsibility for our actions and always aim to improve
- Develop our services in the best interests of our communities

We are INCLUSIVE

We:
- Value everyone's cultural, social and personal needs
- Celebrate our differences and support each other
- Listen to all voices
- Work as a team and learn from each other
- Challenge prejudice and promote acceptance

#TeamMWL

Contents

Part 1

1.1. Statement on quality from the Chief Executive of the Trust

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

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

I would like to take this opportunity to thank my predecessor, Ann Marr OBE, for her tireless commitment to our patients and staff over her 22 years at the Trust. Ann transformed Whiston and St Helens hospitals into the world-class facilities they are today, as well as overseeing the culmination of 18 months' work to bring St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and Southport and Ormskirk Hospital NHS Trust (S&O) together to form a new Trust, MWL, which has enabled us to provide sustainable and high quality services for the populations of Merseyside, West Lancashire and beyond.

2024-25 continued to present many challenges for staff with ongoing demands on an already stretched workforce. Every part of the NHS is under significant pressure at the moment and the areas of Merseyside and West Lancashire are no exception. My focus has, and will be, on making sure that we continue to look after our patients and our staff to provide the highest standards against this challenging backdrop.

There have not been any Care Quality Commission (CQC) Inspections undertaken between 1st April 2024 to 31st March 2025 and MWL continues to retain the outstanding CQC rating. We have maintained contact with our CQC relationship manager throughout the year including regular onsite relationship meetings with CQC colleagues. The Trust has continued to monitor key quality indicators via the monthly comprehensive Corporate Performance Report, which is reviewed by the Board and its Committees.

I was, however, extremely disappointed that during the year there were five never events, relating to a retained guide wire, wrong site steroid injection, wrong site surgery, wrong site nerve block and retained foreign object. Actions have been taken following these as part of the Trust's commitment to learning from incidents and these are outlined in more detail in the report.

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

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

In addition, the Trust reviewed and updated the ward accreditation programme, to ensure it is fit for purpose for the new organisation. The 5 Star Accreditation was launched in June 2024 and by 31st March 2025 all 46 inpatient wards and clinical areas across all of our sites have been assessed which is an amazing achievement. The aim is to continue to roll this programme out to all other areas including theatres and community services in 2025-26. In January 2025, the 5 Star Accreditation was externally reviewed by Mersey Internal Audit Agency (MIAA) and was awarded a high level of assurance. A number of quality ward rounds with members of the Trust Board took place throughout the year across all sites to see and hear first-hand how staff are striving to provide the best possible care for patients that is safe, effective, caring, responsive and well-led.

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

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

We are extremely grateful to our volunteers who make a unique and valuable contribution to patients and carers, relatives, visitors, and staff. The skills and support they provide has a positive impact for people who use our services, including our staff, and the community. An incredible 205 volunteers were recruited across our 5 hospital sites during 2024-25.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting the challenges faced during the year. It outlines our quality improvement priorities for 2025-26.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2024-25 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We trust that it provides you with the confidence that high quality patient care remains our overarching priority and that it demonstrates the care and patient-centred services we have continued to deliver during the ongoing challenges in 2025-26.

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

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

1.2 Celebrating Success in 2024-2025

Celebrating Success in 2024-2025

Our staff make our organisation and to celebrate the outstanding work they undertake we held our first joint MWL staff awards in May 2024. The winners are acknowledged below with the detail of the nominations.

Special Recognition Award	**Sylvia Sinclair, Deputy General Manager** Sylvia began her career as a laundry assistant at Whiston Hospital 49 years ago. Today, she oversees domestic, portering, catering and linen services across Whiston and St Helens hospitals. Always putting the patient at the heart of everything she does, Sylvia's standards are second to none and her commitment to the Trust, her team, and colleagues across all areas of our hospitals is unwavering. Under Sylvia's leadership, Whiston and St Helens hospitals have achieved a remarkable 100% in their cleaning audit scores for the past 8 consecutive years, securing our position as the best patient environment in the NHS. We know it takes a team effort, but every team needs a Sylvia, and we are honoured to recognise her career-long dedication to our hospitals and patients.
Special Recognition Award	**Critical Care Unit, Southport Hospital** Winning the Critical and Emergency Care Nursing Times Awards in 2023, Southport Hospital's Critical Care Unit has been recognised for the compassionate and respectful way they support families and each other following the sad loss of a patient. Through a ground-breaking initiative, called The Pause Campaign, which embraces 60 seconds of silent reflection, the team has made a lasting difference to many. Coming together to recognise the contribution they make to patients at the end of life, staff are able to help families start the grieving process and support each other through some of the most difficult of times. The Critical Care Team is hailed as one of the best in the country, always demonstrating exemplary practice, with a sensitive and human approach. They embody our vision of 5 Star Patient Care.
Excellence in Clinical Care	**Ward 10B, General Surgery, Southport Hospital** This team of dedicated professionals make patient-centred care a priority. One of the busiest surgical wards at the Trust, this well-led team works extremely hard to deliver the highest standards to an increasing number of complex patients. Feedback from patients is overwhelmingly positive, and colleagues across the hospitals praise the team for their consistent professionalism and efficiency.
Excellence in Quality Improvement	**Frailty Urgent Community Response Team** This team have demonstrated remarkable commitment and innovation in addressing the complex healthcare needs of an increasing number of frail elderly people in our community. Ensuring patients receive the highest levels of care and best possible experience, in the right place, first time, their valuable work supports the prevention of avoidable admissions to our very busy hospitals.

Excellence Patient Safety	**Haematology Department** This dedicated multi-disciplinary team provides specialised care for patients being treated for blood disorders and cancers. One of the first to work cohesively across MWL, this service was recently hailed as an exemplar in its field by NHS England. Delivering 5 Star Patient Care across all the communities we serve, they undoubtedly improve outcomes and save lives.
Excellence in Support Services	**Payroll Services** Delivering services to over half of the NHS workforce in Cheshire and Merseyside, this vital team ensures that over 85,000 healthcare staff receive efficient payroll and pension services. In the past 12 months, they have been recognised as one of the best in the country, passing their national audit with flying colours and winning a prestigious payroll innovation award.
Patient Experience Award	**Burney Breast Unit, St Helens Hospital** Outstanding in every way, this team is renowned for the extremely high standards of care they provide to patients with breast conditions and cancer. Led by a nationally acclaimed team of highly skilled specialists, the Burney Breast Unit delivers amazing clinical outcomes and a patient experience that is second to none.
People's Choice Award *Sponsored by the St Helens Star*	**Sanderson Suite, St Helens Hospital** This exceptional team are dedicated to always delivering the highest standards of care, and this is reflected in the overwhelming amount of positive feedback received from patients having day-case surgery. Reassuring and supportive, nothing is too much trouble for this team who make a world of difference to so many patients each and every day.
People's Choice Award *Sponsored by Stand up for Southport*	**Jo Unsworth, Bereavement Midwife, Ormskirk Hospital** Caring for those following the loss of their baby takes a unique combination of compassion, understanding, and the ability to listen to what parents and the family's needs truly are – Joanne embodies all of these values and more. Instrumental in the creation of the Rainbow Team, families say she is a true angel that helps them to grieve, rebuild and prepare for the future.
Employee of the Year	**Sarah McKenna, Advanced Nurse Practitioner, Emergency Department, Whiston Hospital** Described as the best of the best by colleagues, Sarah has helped to drive change in the Emergency Department with her knowledge, experience, and sheer determination to provide the highest standards of care for her patients. She has been pivotal to the newly developed, award-winning, primary care streaming service, that has helped to greatly reduce attendances at Whiston Hospital Emergency Department.
Team of the Year	**Plastic Surgery Department, St Helens & Whiston hospitals** When life gets turned upside down through either illness or injury, this team of highly knowledgeable experts use their exceptional skills to rebuild and transform the lives of their patients. They work tirelessly to deliver innovative surgical solutions and provide outstanding clinical and therapeutic care. Recognised across the NHS as exemplary, this is a team we are incredibly proud of.

1.3 Our Challenges

In 2024-25, there were several challenges faced across the Trust and in our local communities. Both Southport and Ormskirk were receiving hospitals for major incidents that took place in July 2024, including the horrific incident in Hart Street, Southport, and the riots in the surrounding area. These greatly affected our staff and local communities who continue to feel the impact of these devastating events.

In January 2025, MWL amongst other Chesire and Merseyside providers, declared a critical incident due to the intense pressures faced after the Christmas and New Year period. This highlights the considerable system pressures across the region including demand for urgent care, acuity and bed occupancy pressures.

Infection Prevention Control (IPC) in respect of reportable healthcare associated infections, outbreaks, incident management and lessons learned from these remains a key focus and aligned to the Trust's Quality Objectives for 2025-26, including a key focus on reduction of avoidable hospital onset MSSA and to reduce the incidents of MRSA and improve our Aseptic Non-Touch Technique (ANTT) compliance.

Part 2

Priorities for improvement and statements of assurance from the board.

2.1 Quality objectives for improvement during 2025-26

The Trust's quality objectives for 2025-26 are listed below with the reasons why they are important areas for quality improvement. The views of stakeholders and staff were considered prior to the Trust Board's approval of the final list. The consultation included an online survey that was circulated to staff and stakeholders, as well as being placed on the Trust's website for public participation.

The consultation was undertaken using an electronic survey with 52 responses received. There was a high level of agreement with the proposed objectives, all receiving over 90% positive responses, with the exception of infection control at 87%. The proposed objective which received the most support was 'continue to ensure the timely and effective assessment of patients in the Emergency Department' with 96% positive responses.

Further suggested objectives for coming years included:

- Digitisation of documentation
- Back to basics (Kindness and Compassion)
- Focus on care of people with additional needs
- Meal provision and nutrition

It is to be noted that some of the suggestions are already a focus for quality improvement with the Trust having in place a long-term strategy for the digitisation of documentation, back to basics being the focus of our 5 Star Accreditation and the focus on care of people with additional needs being addressed by the Patient Experience Team. We have also recently reinvigorated our focus on nutrition and hydration with the establishment of a Trust-wide group.

No	Objective	Lead Director	Measurement
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, Emergency Department, Maternity with a focus on antenatal.	Chief Nursing Officer	• Improvement against previous year's national survey results in relation to:
			  o Management of pain
			  o Kindness and compassion whilst in hospital
			  o 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 Star Ward Accreditation Programme

1.2	Ensure improvement and sustainability of nutritional standards for patients.	Chief Nursing Officer	• Achieve 95% of adult inpatients screened for malnutrition on admission using the MUST tool • Achieve 95% of patients with a score of 2 or more who receive an appropriate care plan • Improve the processes to ensure 95% of high-risk patients are referred to a dietician • Achieve and maintain 90% for nutrition score consistently across all wards for the 5 Star Ward Accreditation Programme

1.3	Improve measurable success for families who access antenatal services who have told us we didn't get it right first time	Chief Nursing Officer	• Improvement against previous year's national survey results via quarterly surveys
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.	Chief Nursing Officer	• 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
2.2	Improve the Trust's compliance with IPC standards.	Chief Nursing Officer	• 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 Star Ward Accreditation programme
5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcomes, whilst recognising the specific individual needs of every patient**			
3.1	Continue to improve the effectiveness of the discharge process for patients and carers.	Chief Operating Officer	• 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

2.2 Statements of assurance from the Board

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

2.2.1 Review of services

During 2024-25, the Trust provided and/or sub-contracted £935m NHS services.

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

The income generated by the NHS services reviewed in 2024-25 represents 94% of the total income generated from the provision of NHS services by MWL for 2024-25.

2.2.2 Participation in Clinical Audit

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

During 2024/25, 64 national clinical audits and seven national confidential enquiries covered NHS health services that Mersey and West Lancashire Hospitals NHS Trust provides. During that period the Trust participated in 98% national clinical audits and 100% national confidential enquiries, of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits that Mersey and West Lancashire Teaching Hospitals NHS Trust participated in during 2024-25 are listed in appendix 1.

The national confidential enquiries that MWL was eligible to participate in during 2024-25 are as follows:

Name of Study	Status during 2024-25	MWL Position
Blood Sodium	Data Collection	Awaiting final report
Emergency procedures in children and young people	Data Collection	Awaiting final report
Acute Limb Ischaemia	Data Collection	Still active
Acute illness in people with a Learning Disability	Data Collection	Still active
Juvenile Idiopathic Arthritis	Report Published	Gap Analysis Stage
End of Life Care	Report Published	Gap Analysis Stage
Endometriosis	Report Published	Gap Analysis Stage

The reports of 216 local clinical audits were reviewed by the provider in 2024-25 and MWL has taken and intends to take the following actions to improve the quality of healthcare provided.

Re-audit of Delirium Guidelines

The project is a re-audit against the NICE guideline NICE CG103 – delirium: prevention, diagnosis and management (2023).

The **4 'A's Test** (**4AT**) is a bedside medical scale used to help determine if a person has positive signs for delirium. The 4AT also includes cognitive test items, making it suitable also for use as a rapid test for cognitive impairment. Our aim was to improve the use of the 4AT – in 2019 when the first audit was undertaken 0% of patients had a 4AT completed.

Improvement:

2019 = 0%

2020 = 38%

2022 = 72%

2023 = 100%

2024 = 96%

The improvement has been achieved due to the work of the dementia and delirium team. Over the last 4 years the team have delivered education to nursing and medical staff of all grades regarding the identification, prevention, treatment and causes of delirium, as well as strategies for staff and families to help to resolve acute confusion, and reinforcing the need for reassessment and follow up when patients return home. Working with the bed management team we have implemented the "Keep Me Here" initiative for patients with complex symptoms of dementia and slow to resolve delirium to prevent worsening symptoms by reducing their number of bed moves while in hospital.

Introducing an Ambulatory Pleural Effusion Pathway at Whiston Hospital

A 3-month audit of all inpatient pleural referrals found only 27% of patients meeting criteria for appropriate ambulatory care were discharged to ambulatory pleural clinic. Patients that were not ambulated had an average 3.5-day inpatient stay compared to less than 1 day for those ambulated.

SMART Aim: By July 2024, 100% of eligible pleural effusion patients are discharged home and ambulated to outpatient pleural clinic via newly implemented pleural referral pathway.

Changes made

- Creation of a new Trust Ambulatory Pleural Pathway which provides guidance to the referrer to optimise the referral process
- Education around ambulation of appropriate pleural effusion patients meaning the patients are discharged home quicker and brought back to pleural clinic as an outpatient for specialist respiratory review and appropriate investigations.

Improvement following intervention

- Improved identification of patients who are eligible for referral to pleural clinic
- 100% appropriate ambulation rate with all patients correctly referred via the new pleural pathway
- No complications or unexpected readmissions resulted from patients being ambulated

Improving Neonatal Optimisation in Ormskirk Hospital

In July 2023 NHS England published Saving Babies' Lives version 3 (SBL3) which is a care bundle for reducing perinatal mortality. There are 6 elements of care which are monitored quarterly by the Local Maternity and Neonatal System (LMNS).

This quality improvement initiative focused on Element 5 and the optimisation of perinatal care:

Element 5 - reducing preterm birth recommends three intervention areas to reduce adverse fetal and neonatal outcomes: improving the prediction and prevention of preterm birth and optimising perinatal care when preterm birth cannot be prevented.

Improvements we have made during 2024-25

	SBL3 Target	Our Improvement
1. Percentage of women who deliver preterm where the neonatal team have a discussion with the parents regarding care options	70%	Achieving 100%
2. Perinatal optimisation pathway compliance	70%	Achieving 86%
3. Magnesium sulphate to be offered to women between 22+0 and 29+6 weeks of pregnancy who are in established labour or are having a planned preterm birth within 24 hours	85%	Achieving 100%
4. All women in preterm labour at less than 37 weeks of gestation should receive intravenous intrapartum antibiotic prophylaxis	25%	Achieving 100%
5. Babies born less than 37 weeks have their umbilical cord clamped at or after one minute after birth	70%	Achieving 100%
6. Babies born less than 37 weeks gestation should have a first temperature which is between 36.5 and 37.5 within one hour of birth	70%	Achieving 100%
7. Babies born less that 37 weeks gestation should receive their own mother's milk, ideally within 6 hours but aiming within 24 hours of birth	30%	Achieving 80%

Smoking Screening of Inpatients within MWL

We are very proud of the impact the tobacco dependency team has had on improving the provision of smoking cessation services within MWL.

- Improved screening was achieved through the education and training of ward staff including nurses, doctors, pharmacists, and therapists in screening inpatients admitted into hospital who are current smokers. This training was delivered in a number of different ways and methods to accommodate everyone's different style of learning. This included face to face sessions, quality bus visits to different areas, 1:1 on the spot training on the wards, meetings over teams with various hospital departments, and lunch and learn sessions with doctors and preceptees.
- Improved Nicotine Replacement Therapy (NRT) was achieved by updating the NRT Standard Operating Procedure to ensure it was in line with NICE current guidelines and expanding the strength of patches available for prescription from only 24 hour to also having a 16 hour patch available on the wards. This is an immediate benefit to patients as the 24 hour patch only works well for patients who will get up and smoke during the night and can cause nightmares for people who do not smoke during the night.
- Education on nicotine replacement therapy, for instance dispelling the myth that patients had to remove their NRT patch when going for an MRI or X-ray because it contained metal.
- Referral to Smoking Cessation Services was improved by the fact the new lead for the Tobacco Services with MWL had previously worked in the community setting and had built up important working relationships with the necessary services. The team also developed a spreadsheet that would prompt the tobacco dependency advisor, the member of the team who visits the wards, to make the referral to community services appropriately once a patient has been discharged. This was beneficial to nursing staff as it reduced workload and also ensured more referrals were completed accurately and therefore accepted by community services.

Improvements

- Smoking Assessment rates have improved from 32% (October 2023) to 66% (February 2024)
- Nicotine Replacement Therapy being offered has increased month on month since April 2024 and we are now second in the Cheshire and Mersey Region for providing NRT
- Referral to Community Smoking Cessation Services has increased month on month: April 2024, 67 patients; January 2025, 116 patients
- Rated A for the 10 data quality points required by NHS England for monthly smoking cessation data upload.

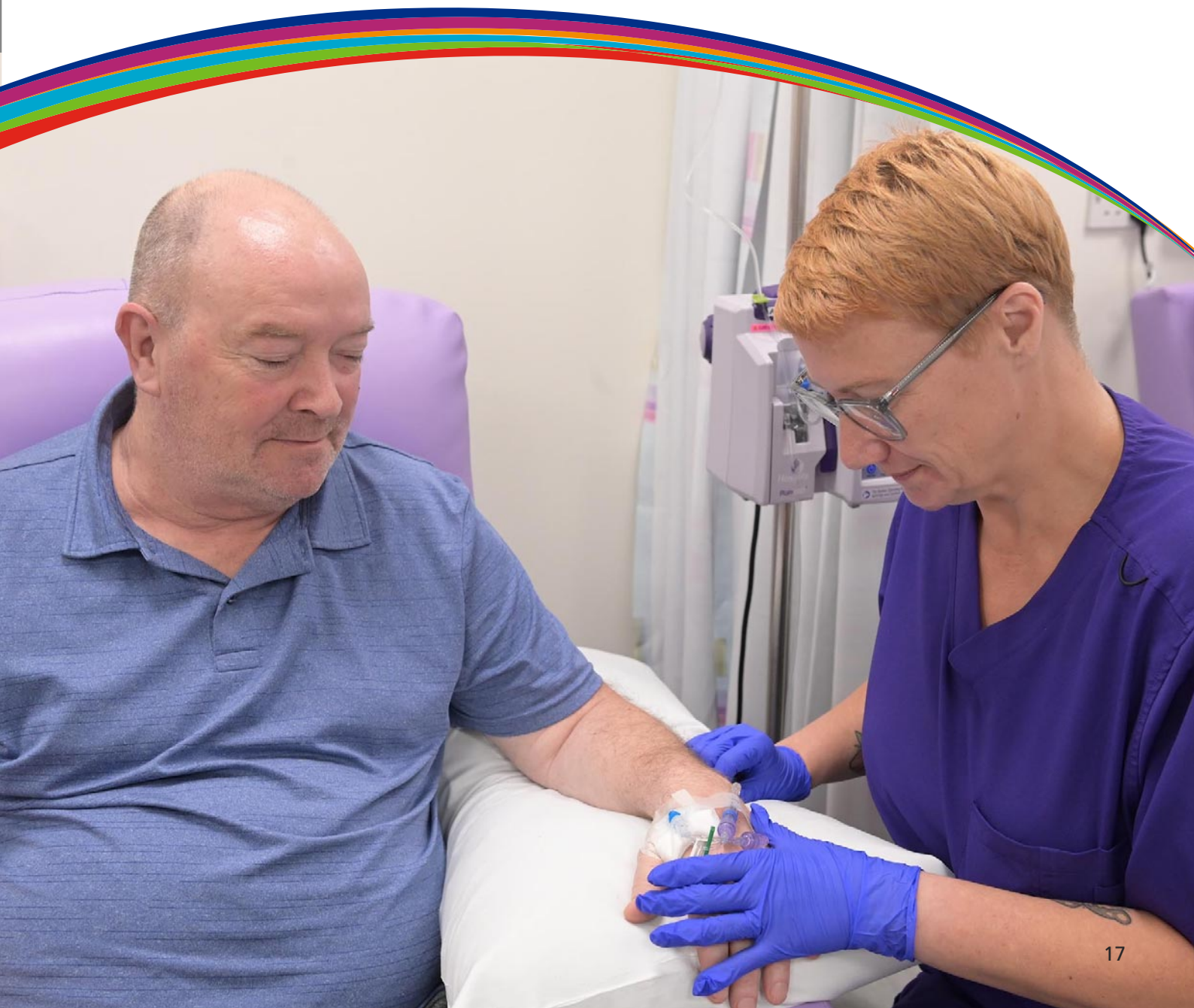
2.2.3 Participation and Recruitment in Clinical Research

Participating in clinical research demonstrates MWL's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The aim of clinical research is to offer patients access to new and emerging treatments. MWL is committed to delivering safe and effective high quality patient-centred services, based on the latest evidence and clinical research. Our focus is on improving care, developing better treatments and increasing our understanding of disease by providing an environment that is conducive to the undertaking of quality research and development activities.

In 2024-25 2046 patients receiving relevant health services provided or sub-contracted by MWL were recruited to participate in research approved by a Research Ethics Committee/Health Research Authority.

All sites met their annual recruitment target, recruiting 2046 participants against a target of 1400. This is the result of a huge effort from all the staff within the Research, Development and Innovation (RDI) Department; and demonstrates the team's commitment to offering patients and the public the opportunity to take part in research.



The number of research studies open to recruitment at the Whiston, St Helens and Newton hospital sites during 2024-25 was 77 compared to 76 in 2023-24. The number of studies that were issued with Confirmation of Capacity & Capability (MWL NHS Permission) in 2024-25 was 26 compared to 27 in 2023-24. For the Southport and Ormskirk sites there was an increase in the number of studies that were issued with Confirmation of Capacity & Capability, 52 in 2024-25 compared to 49 in the previous year.

During 2024-25 the Whiston Hospital site had 15 active commercial studies in its portfolio, this included studies in which patients were followed up with after concluding their treatment. The Southport and Ormskirk hospital sites have been progressing an important commercial study, the RADIANT study, supporting the treatment of type 1 diabetes in children and adults. This is an increase in our commercial activity since 2023-24 and demonstrates our commitment to focusing on commercial research. It also allows our patients the benefit of earlier access to new treatments and technologies.

Commercial Research Delivery Centre

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 faster than before. 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.

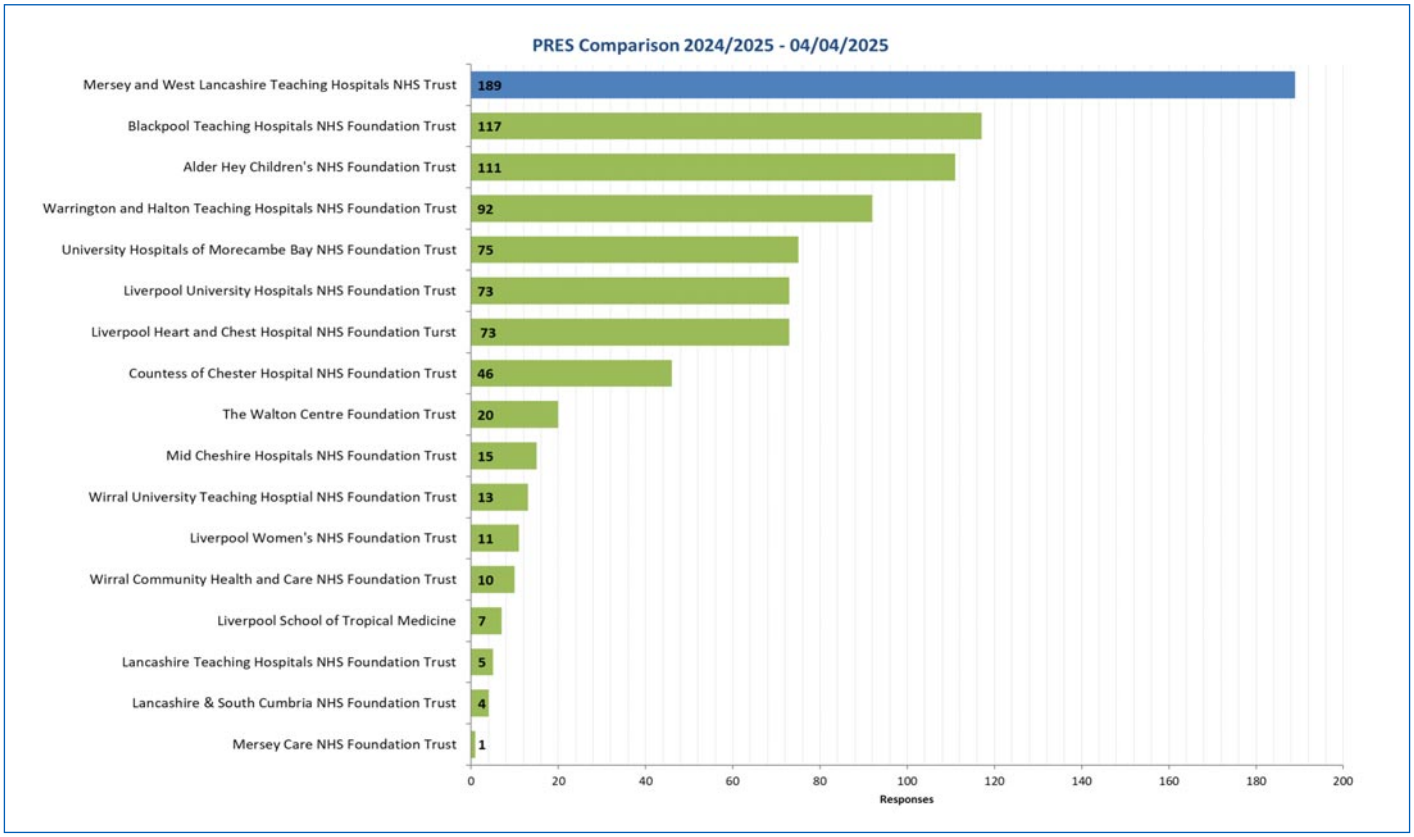
The host for the new NIHR Commercial Research Delivery Centre (CRDC) is NHS University Hospitals of Liverpool Group (UHLG), formerly known as Liverpool University Hospitals. In 2024 MWL was notified that it had been successful in a bid to become one of its 10 spoke organisations. The new, purpose-built research facilities will enable 'efficient delivery of research studies and a smooth, pleasant and safe experience for study participants'. 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, and ongoing care and monitoring as part of a research study.

Research Hubs

In 2024, MWL opened two new Research Hubs at Ormskirk Hospital and Marshalls Cross GP Surgery in St Helens. We have also expanded the existing Research Hub based at Whiston Hospital. These developments utilised the National Institute for Health & Social Care Infrastructure funding that was secured at the end of 2023. Our Research Hubs 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.

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. We are pleased that for 4 out of the past 5 years MWL has received the most responses to the PRES, and in 2024-25 we were top of the PRES dashboard by a substantial margin.



2.2.4 Clinical goals agreed with commissioners

In 2024-25, the nationally mandated CQUIN scheme was paused whilst a wider review of incentives for quality is undertaken.

2.2.5 Statements from the Care Quality Commission (CQC)

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

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

If the CQC has cause for concern, it may undertake special reviews/investigations and impose certain conditions. There have not been any CQC inspections undertaken between 1st April 2024 to 31st March 2025, and MWL continues to retain its Outstanding CQC rating.

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

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

The Care Quality Commission has not taken enforcement action against MWL during 2024-25.

In the last financial year (2023-24), both Urgent and Emergency Care (UEC) services at Southport and Whiston hospitals received unannounced inspections. Final reports were published in January and April 2025, the results of these inspections did not impact the Trust's overall rating. Plans are in place following the published reports to make identified improvements in triage, ambulance turnaround times, and waiting times to access specialities. Staff and leaders were commended in the report.

2.2.6 Information Governance Toolkit

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

The Trust uses the Data Security and Protection Toolkit (DSPT) to benchmark its IG and IT security controls, also known as the IG Assessment Report. The DSPT is an annual online self-assessment tool that allows health and social care organisations to measure their performance against the National Data Guardian's 10 Data Security Standards (covering topics such as staff responsibilities, training, and continuity planning) and reflects legal rules relevant to IG. The Trust must address all mandatory requirements within the DSPT in order to publish a successful assessment.

The 2023-24 DSPT was submitted in June 2024. This was the first DSPT as MWL. Prior to this the two separate legacy organisations, St Helens and Knowsley Teaching Hospitals NHS Trust, and Southport and Ormskirk Hospital NHS Trust had demonstrated their IG and IT security controls via the DSPT independently, both submitting in the required timeframe and achieving substantial assurance via an independent audit.

This 2023-24 DSPT was also audited by Mersey Internal Audit Agency, who check the quality and veracity of the evidence that has been provided. MWL's first DSPT achieved 'substantial assurance.' All key Information Governance policies were created and approved for MWL during 2023-24, including the critical Data Breach Management Policy and Procedure which is adhered to when a personal data breach/incident occurs. All incidents during 2023-24 were risk assessed and scored; it is a requirement that any incidents scoring highly are reported to the Information Commissioner's Office (ICO). In April 2024 MWL had one incident that when scored met the criteria to report to the ICO - the ICO were informed of the lessons learned and action plan the Trust had put in place. To date no further actions have been received from the ICO.

The Trust has assigned specific roles to ensure the IG framework is adhered to and is fully embedded:

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

All three staff are appropriately trained.


NHS

2.2.7 Cyber Security

In 2024-25 there has been a focus on our cyber security services ensuring our data and systems are protected. A significant amount of work goes into keeping up with the ever-developing threats across the globe which can result in severe disruption to services as seen at local Trusts within the region. The team has recently been working with national services to onboard all our devices to the national offering for actively monitored 24/7 services. This ensures that even out of hours cyber specialists are monitoring and responding to threats on our estate.

2.2.8 Clinical coding

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

MWL was not subject to the Payment by Results clinical coding audit during 2024-25 by the Audit Commission.

The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Data Security and Protection Toolkit (DSPT) 2024-25.

It is widely known throughout the NHS that there is a local and national shortage of qualified and experienced Clinical Coders, which unfortunately creates recruitment challenges for Clinical Coding departments across the country. Despite vacancy challenges faced by the team, the Trust and wider community should be reassured that the data reported at MWL is accurate and reflects the activity that is taking place, demonstrated by the 2024-25 DSPT clinical coding audit submission achieving a high standard of accuracy.

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

Mersey and West Lancashire Teaching Hospitals NHS Trust			
	%	**Audited**	**Errors**
Primary Diagnosis	93.00	200	14
Secondary Diagnosis	96.17	758	29
Primary Procedure	96.30	189	7
Secondary Procedure	94.01	334	20

MWL will be taking the following actions to improve data:

- Continuing to promote clinical engagement to ensure that clinical coding accurately reflects the patient journey
- Ensuring staff are working towards achieving the national clinical coding qualification (NCCQ)
- Ensuring staff attend regular refresher workshops to ensure coding skills are kept up to date
- Continuing to provide a robust audit service to highlight areas for improvement

2.2.9 NHS number and General Medical Practice Code Validity

During 2024-25 MWL submitted records to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and the patient's valid registered GP practice code contributes to the overall Data Quality Maturity Index (DQMI) scores. The DQMI score for the most recent 12 months is shown in the table below.

DQMI	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Trust Score	92.7	92.8	92.9	93.2	93.6	93.4	93.1	93.6	93.5	93.5	93.6	92.7	93.6
National Average	81.8	81.2	81.4	81.4	80.3	79.3	80.7	78.5	73.8	71.8	72.4	72.1	74.1

(Source: DQMI)

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

The Trust takes the following actions to improve data quality:

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

2.2.10 Data quality

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

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

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

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

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

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

2.2.11 Learning from deaths

MWL has well-established processes across all sites to review deaths occurring in hospital and identifying areas of learning where practice can be improved. The delivery of the Learning from Deaths (LFD) processes were different in the two organisations which came together to form MWL in July 2023 but both follow the guidance for NHS providers as set out by the National Quality Board (NQB) on how organisations should learn from the deaths of people in their care.

Hospital Site	Process
Southport and Ormskirk	All deaths in hospital reviewed by Medical Examiner (ME) Team and feed into the LFD process. Any concerns around lapses in care referred for Structures Judgement Review (SJR) and logged via Incident Reporting System. Mortality Outcomes Group reviews learning from ME reviews and SJRs.
Whiston and St Helens	Separate ME and LFD process. Deaths in hospital within scope referred for SJR and review at Mortality Surveillance Group. Any concerns around lapses in care logged via Incident Reporting System.

Cases are rated as Amber when areas are identified as possibly contributing to patient harm. Cases are rated as Red when the death was identified as being more likely than not due to problems in healthcare (i.e. avoidable). All cases rated as Amber or Red are reviewed within their respective Mortality Groups by the LFD and a final rating is given. Any learning is fed back to the Divisional team and shared throughout the organisation to ensure that all staff are given the opportunity to determine how this could impact on their practice, in order to make improvements for other patients.

The process to merge the two review groups (Mortality Outcomes Group and Mortality Surveillance Group) has begun in order to have a single Trust-wide group for review of in-hospital deaths. Both groups work closely with Specialist Palliative Care Teams to identify actions which can be taken to improve End of Life Care.

During Quarters1-4 2024-25, 2667 of MWL's patients died in hospital. This comprised the following number of deaths which occurred in each quarter of that reporting period:

657 in Q1
649 in Q2
657 in Q3
704 in Q4

By the end of Quarter 4, 246 case record reviews and 4 investigations (Reds and Ambers) have been carried out in relation to the 2,667 deaths included in item 2.4.6.1.

In 4 cases (Reds and Ambers), a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

2 in Q1
1 in Q2
1 in Q3
0 in Q4

0 represents that 0.00% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient (Red rated).

In relation to each quarter, this consisted of:

0 representing 0% for Q1
0 representing 0% for Q2
0 representing 0% for Q3
0 representing 0% for Q4

To date the LFD results have been presented for Quarter 1 and Quarter 2 of 2024-25 to the Trust Board:

For Quarter 1 (April-June) at Whiston and St Helens hospitals:

Total cases with Structured Judgement Review (SJR) Quarter 1	63
Total outstanding a review Quarter 1	4
Total Red SJRs Quarter 1	0
Total Amber SJRs Quarter 1	2

For Quarter 1 (April-June) at Southport and Ormskirk hospitals:

Total cases with ME Case Record Review Quarter (CRR) 1	177
Total cases with Structured Judgement Review (SJR) Quarter 1	6
Total Red CRR/SJR Quarter 1	0
Total Amber CRR/SJR Quarter 1	3

For Quarter 2 (July-September) at Whiston and St Helens hospitals:

Total cases with Structured Judgement Review (SJR) Quarter 2	45
Total outstanding a review Quarter 2	25
Total Red SJRs Quarter 2	0
Total Amber SJRs Quarter 2	0

For Quarter 2 (July-September) at Southport and Ormskirk hospitals

Total Number of CRR Quarter 2	192
Total Red CRR Quarter 2	0
Total Amber CRR Quarter 2	4

Summary of learning from deaths

- Availability of translation services to support care of patients unable to speak English
  - Work for patients attending for elective care has been completed.
  - 24 hours telephone / videoconference facilities are available. Work is commencing to raise awareness of these options.
- Intravenous access
  - Obtaining and maintaining appropriate intravenous access in patients is a multi-factorial challenge and is placing increased pressure on other services.
  - An Intravenous Therapy Group has been established to review and improve these pathways.
- End of life planning
  - A focus on issues with planning when recovery is uncertain, conversations with patients and loved ones in difficult and emotive situations and processes to promote earlier planning toward the end of life.

- Trust-wide group set up and training available to all senior clinical staff in escalation planning in clinical uncertainty, delivered via a collaboration between acute specialties and palliative care.

- Nutrition and hydration
  - Delays in appropriate provision of this due to delayed decision making and appropriate use of the Speech and Language Therapy (SALT) service.
  - Nutrition group formed to understand the frailties in the process and what options are available to staff to promote appropriate nutritional delivery.
- Escalation
  - Case reviews indicate a frailty in the process of escalation when the next most senior clinician in the team is unavailable. There is a tendency for the escalation process to be delayed or referred back 'down' to a junior colleague.
- Know your pathways
  - Trust pathways have been developed following local and national guidance of significant events and learning within the healthcare environment. It is imperative that staff familiarise themselves with what pathways are available within their field of practice, then follow them accordingly. They are there to protect both our patients and our staff.
- Communication with families / carers
  - At times of high emotion and distress, it may be that families and carers do not take in what is happening to their loved one and may not be able to comprehend a poor diagnosis. This is often even more challenging over telephone call. Staff must remain aware of verbal and physical cues from families / carers suggesting key messages haven't been fully appreciated, so the communication can be reinforced accordingly.
- Imaging with Contrast
  - Inpatients who receive imaging with contrast are at a higher risk of renal complications if their fluids are not correctly managed. Staff should consider IV fluids for these patients as they are particularly vulnerable.
- Observe caution in the use of Lorezepam in the elderly
  - Guidance is given in the Delerium assessment and management pro-forma under the elderly & frail medication, ED section of the intranet.
- DNACPR communications on Transfer
  - On a transfer form there is a specific box to indicate a DNACPR is in place, this must be ticked and they must ensure the Lilac form is prominent at the front of the case.
- GKI (Glucose / Potassium / Insulin regime)
  - This is only to be used with patients who have a definite diagnosis of diabetes. If used on patients that are non-diabetic, this can lead to a detrimental outcome.
- Palliative Care (SPCT)
  - Methadone should not be stopped - this can be given via syringe driver.
  - Blood glucose monitoring may still be required on a dying patient who is T1DM to prevent further detrimental impact of a hypoglycaemic episode during their vulnerable stage of dying
  - Parkinsons medication can be converted to a patch.
  - Anti-convulsion medication should not be stopped, can be given via a syringe driver.
  - Fentanyl patches must not be removed, they are to be continued to be replaced as patients are dying.
  - Consider environmental factors before using benzodiazepines i.e. has the patient has passed urine, have we prescribed a nicotine patch, when did they last have their bowels open.
  - Do not give midazolam to patients who have a nonterminal dementia and dementia symptoms, this is only to be used for these patients when they have terminal agitation.

Following the creation of MWL, work is underway to align the two Learning from Deaths processes into one process. Once created and approved this will be reflected in a new MWL Learning from Deaths Policy. It is anticipated that this will be complete by Quarter 3 2025-26.

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

2.2.12 Freedom to speak up

The Trust has an established system to encourage and support staff to have the freedom to raise concerns. Staff are encouraged to not only speak up about anything that gets in the way of delivering great care and treatment, but also about areas of good practice that could be replicated elsewhere.

The Trust has four Freedom to Speak Up (FTSU) Guardians, two of whom undertake a dedicated role to both support staff and the development of a speak up, listen up and follow up culture, within the organisation. The team is supported by a FTSU Specialist Administrator and a developing network of FTSU Champions, who come from different professional groups and work at various levels and roles within the Trust. Whilst Champions primarily support the culture within the teams in which they are embedded, they may also offer support and signposting to any staff member within the Trust. Guardians and Champions come together once a month to share information and develop ideas for further developing the culture.

Staff are encouraged to speak up and raise any concerns within their own teams, however they can also access support via the FTSU Guardians and Champions. They can raise concerns via the web-based Speak in Confidence system, by email to a dedicated inbox, and via a hotline to the Medical Director, who is also a FTSU Guardian.

FTSU Guardians participate in corporate staff inductions and offer an array of sessions to individual departments or as part of a training programme. Our FTSU Guardians meet on a regular basis to discuss any emerging trends, whilst maintaining confidentiality regarding individual cases.

The Trust Board completed a self-assessment of the FTSU arrangements within the Trust using the National Guardian's Office and NHS England's Reflection and Planning Tool. This has been reviewed in March 2025. The outcome of the assessment and subsequent review has been used to develop an action plan for continuous improvement in line with the draft updated merged FTSU Strategy.

Each year Freedom to Speak Up month is celebrated in October. The theme for 2024's events was 'listening up', with several activities undertaken to raise awareness of speaking up including:

- Away Day for Champions for learning and to set priorities for the year ahead
- FTSU Executive Lead walkabouts across sites
- FTSU Guardian and Champions walkarounds on each site
- Information stands on each site with staff encouraged to make a FTSU pledge
- Distribution of quizzes and word searches relating to speaking up
- Wear Green Wednesdays
- Team take-over on Trust Brief Live in the first week of October
- Ongoing recruitment of FTSU champions across all Trust sites
- Contract extended for the anonymous Speak in Confidence system across all sites

The FTSU system is complementary to the just and learning culture adopted by the organisation.

Following analysis of FTSU cases the Trust themes are in line with the national picture, where inappropriate behaviour and staff wellbeing are the most significant themes. To support in addressing this a Freedom to Speak Up Guardian is now present on the Leadership Development course and the Foundation Leadership course.

When a FTSU Guardian has supported a member of staff to raise concerns, feedback is requested before a case is closed. There is consistent positive feedback from staff in relation to the support offered by guardians, with examples below:

"I felt listened to and my questions and anxieties were taken seriously."

"Very easy to talk to, felt like my concerns were being listened to. FTSU Guardian kept in touch during the process and was kind and understanding."

"Grateful for the professionalism, but also the compassion which was shown."

"I would speak up again and found the service from the Guardian positive."

"FTSU Guardian got involved quickly to address the concerns and acted properly with involving proper managers for investigation and satisfactory outcome"

"Communication was good and I am grateful that we have you in the Trust"

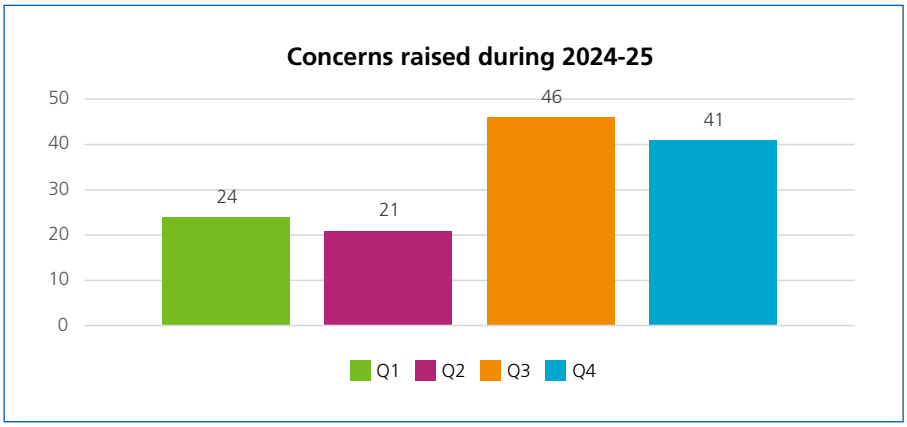
"I would recommend this facility to any member of staff"

"Would like to thank you for all your help and support during this very unsettling period within the department."

"I felt that the concern I raised was dealt with quickly and efficiently by the Guardian and I would have no hesitation in using again"

"I felt reassured right from the start"

"Offered extra support for the department which is fantastic"



Staff are also asked if they feel they have suffered detriment because of speaking up. There was one case of detriment reported during 2024-25 where a member of staff chose to leave the organisation after raising concerns.

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

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

Health, work and wellbeing hotline

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

Hate crime reporting

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

Policies and procedures

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

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

2.2.13 NHS Doctors in Training

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

High level data

- Number of doctors and dentists in training (total): 266 hosted trainees and 165 locally employed foundation trainees.
- The medical vacancy rate is 1.8%.

Exception Reports								
Period	**Medicine**	**Surgery**	**Emergency Medicine**	**Orthopaedics**	**Paediatrics**	**Urology**	**Obst & Gynae**	**TOTAL**
April - June 24	17	16	1	6	1	3	1	45
July 24 - Sept 24	49	36	0	7	1	2	0	95
Oct 24 - Dec 24	32	7	3	1	1	0	0	44
Jan 25 - Mar 25	27	11	1	1	1	0	1	42
TOTAL	125	70	5	15	4	5	2	226

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

Issues arising

The last few years have proved challenging for the junior doctor workforce, working through the Trust merger. The merger has brought about an integration of clinical services, which resulted in further periods of disruption due to increased training needs and transfer time.

2.2.14 Reporting against core indicators

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

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

Summary Hospital-level Mortality Indicator (SHMI)

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
SHMI	NHS Digital	Dec-23 to Nov-24	1.025	1.000	0.702	1.285
SHMI	NHS Digital	Nov-23 to Oct-24	1.028	1.000	0.697	1.299
SHMI	NHS Digital	Oct-23 to Sep-24	1.026	1.000	0.697	1.309
SHMI	NHS Digital	Sep-23 to Aug-24	1.046	1.000	0.697	1.324
SHMI	NHS Digital	Aug-23 to Jul-24	1.067	1.000	0.704	1.323
SHMI	NHS Digital	Jul-23 to Jun-24	1.059	1.000	0.695	1.312
SHMI Banding	NHS Digital	Dec-23 to Nov-24	2	2	3	1
SHMI Banding	NHS Digital	Nov-23 to Oct-24	2	2	3	1
SHMI Banding	NHS Digital	Oct-23 to Sep-24	2	2	3	1
SHMI Banding	NHS Digital	Sep-23 to Aug-24	2	2	3	1
SHMI Banding	NHS Digital	Aug-23 to Jul-24	2	2	3	1
SHMI Banding	NHS Digital	Jul-23 to Jun-24	2	2	3	1
% of patient deaths having palliative care coded	NHS Digital	Dec-23 to Nov-24	50.2%	44.1%	16.9%	66.1%
% of patient deaths having palliative care coded	NHS Digital	Nov-23 to Oct-24	50.7%	44.0%	16.5%	65.6%
% of patient deaths having palliative care coded	NHS Digital	Oct-23 to Sep-24	51.0%	43.8%	16.7%	67.3%
% of patient deaths having palliative care coded	NHS Digital	Sep-23 to Aug-24	50.8%	43.7%	16.9%	66.7%
% of patient deaths having palliative care coded	NHS Digital	Aug-23 to Jul-24	50.7%	43.6%	17.4%	67.0%
% of patient deaths having palliative care coded	NHS Digital	Jul-23 to Jun-24	51.3%	43.6%	17.7%	68.8%

MWL considers that this data is as described for the following reasons:

- Information relating to mortality is monitored monthly and used to drive improvements.
- The mortality data is provided by an external source (NHS Digital).

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

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

Patient Reported Outcome Measures (PROMS)

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

Indicator	Source	Reporting Period	SOHT	STHK	National Performance		
					Average	Lowest Trust	Highest Trust
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-21 to Mar-22 (final)	*	0.396	0.462	0.393	0.534
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-21 to Mar-22 (final)	*	0.256	0.324	0.181	0.417

MWL considers that this data is as described for the following reason:

- The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation (IQVIA).

MWL has taken the following action to improve these outcome scores, and so the quality of its services, by:

- Reviewing the process for PROMs collection Trust-wide and agreeing a Trust-wide forum where results will be discussed.

Friends and Family Test (FFT)

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Jan-25	86.1%	79.8%	55.6%	97.4%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Dec-24	83.4%	75.8%	12.5%	95.2%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Nov-24	82.7%	76.8%	36.4%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Oct-24	83.1%	77.9%	60.0%	96.4%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Sep-24	85.8%	79.2%	53.1%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Aug-24	90.5%	82.6%	66.6%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Jul-24	84.5%	79.8%	61.4%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Jun-24	87.0%	78.6%	59.6%	95.7%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Jan-25	92.4%	94.7%	71.8%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Dec-24	92.5%	94.4%	71.8%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Nov-24	94.7%	94.9%	74.6%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Oct-24	93.8%	94.5%	81.5%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Sep-24	94.7%	94.4%	53.7%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Aug-24	94.7%	94.9%	82.7%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Jul-24	95.4%	94.9%	81.0%	100.0%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Jun-24	94.6%	94.2%	55.9%	100.0%

MWL considers that this data is as described for the following reasons:

- The Trust actively promotes the FFT across all areas.
- The data was submitted monthly to NHS England.

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

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

Venous Thromboembolism (VTE)

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 4 2024-25	81.1%			
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 3 2024-25	83.2%	90.4%	13.7%	100.0%
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2024-25	66.4%	89.0%	14.3%	100.0%
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2024-25	67.1%	88.6%	14.9%	100.0%

MWL considers that this data is as described for the following reasons:

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

MWL is taking the following actions to improve this percentage, and so the quality of its services, by:

- Utilising IT systems and pathways to facilitate VTE risk assessment and prescribing of thromboprophylaxis.
- Undertaking audits on the administration of appropriate medications to prevent blood clots.
- Completing investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed.
- Sharing any learning from these reviews and providing ongoing training for clinical staff.

C. Difficile

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
C. Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-23 to Mar-24	51.0	29.5	0	131.2
C. Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-22 to Mar-23	46.6	27.3	0	133.6
C. Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-21 to Mar-22	46.5	25.2	0	138.4
C. Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-20 to Mar-21	41.6	22.2	0	140.5

MWL considers that this data is as described for the following reasons:

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

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

- Focusing on ensuring staff compliance with mandatory training for infection prevention.
- Ensuring compliance with IPC practice including isolation of patients with suspected / confirmed symptoms.
- Actively promoting the use of hand washing and hand gels to those visiting the hospital.
- Providing a proactive and responsive infection prevention service to increase levels of compliance.
- Ensuring comprehensive guidance is in place on antibiotic prescribing.

Infection prevention remains an ongoing priority for the Trust.

Incidents

Incidents per 1,000 bed days	Internal	Apr-23 to Mar-24	S&O 48.73	STHK 62.13
Incidents per 1,000 bed days	Internal	Apr-24 to Mar-25	MWL 53.263	
Number of incidents	Internal	Apr-23 to Mar-24	S&O 8372	STHK 17469
Number of incidents	Internal	Apr-24 to Mar-25	MWL 23705	
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Apr-23 to Mar-24	S&O 0.08	STHK 0.137
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Apr-24 to Mar-25	MWL 0.124	
Number of incidents resulting in severe harm or death	Internal	Apr-23 to Mar-24	S&O 13	STHK 39
Number of incidents resulting in severe harm or death	Internal	Apr-24 to Mar-25	MWL 55	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-23 to Mar-24	S&O 0.16%	STHK 0.22%
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-24 to Mar-25	MWL 0.23%	

MWL has taken the following actions to improve this number and rate, and so the quality of its services by:

- Undertaking comprehensive investigations of incidents resulting in moderate or severe harm.
- Delivering simulation training to enhance team working in clinical areas.
- Providing staff training in incident reporting and risk management.
- Monitoring key performance indicators at the Patient Safety Council, Quality Committee and the Trust Board.
- Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.

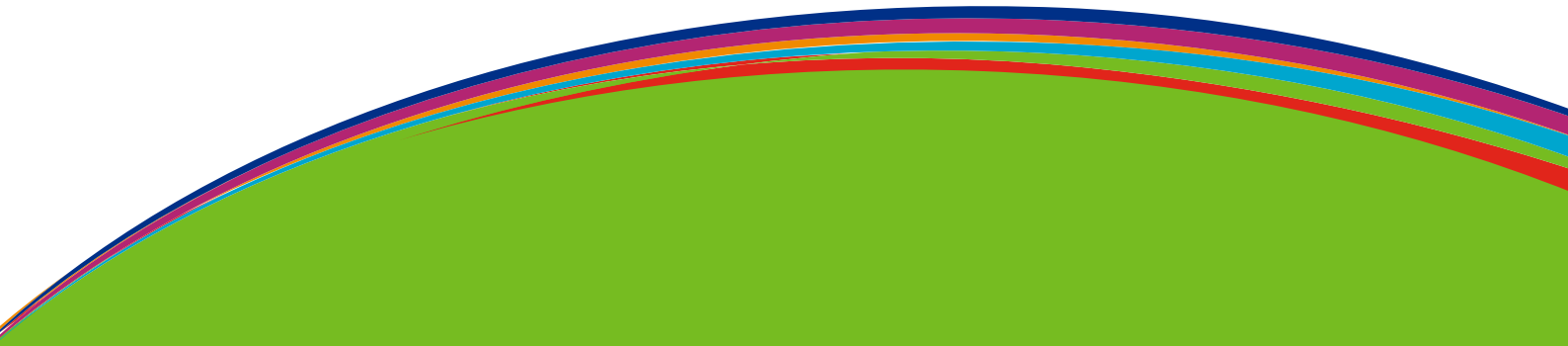
2.2.15 Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2024-25 is shown in the table below:

Performance Indicator	2023-24 Performance	2024-2025 Performance
Cancelled operations (% of patients treated within 28 days following cancellation)	92.40%	88.0% *(Apr-Feb)*
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	60.80%	64.6%
Cancer: 31 day wait from diagnosis to first treatment	91.70%	90.0% *(Apr-Feb)*
Cancer: 62 day wait for first treatment from urgent GP referral	78.1%	79.2% *(Apr-Feb)*
Cancer: 28 day wait from GP referral to Diagnosis informed	69.50%	74.0% *(Apr-Feb)*
Emergency Department waiting times within 4 hours – all types (mapped performance)	74.90%	78.1%
Percentage of patients who spent at least 90% of their stay on the stroke unit.	85.30%	*Awaiting update*
Clostridium Difficile	103	114
MRSA bacteraemia	6	6
Maximum 6-week wait for diagnostic procedures: % of diagnostic waits waited <6 weeks	87.80%	93.1%


hello my name is
CHRISTINE

Part 3. Other information



This section of the Quality Report provides information on our quality performance during 2024-25. Performance against the priorities identified in our previous quality report and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Oversight Framework are outlined. We are proud of a number of initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

1	Southport & Formby Hospital
2	Ormskirk Hospital
3	Whiston Hospital
4	St Helens Hospital
5	Newton Community Hospital
6	Knowsley College
7	Rainhill Clinic
8	Four Acre Medical Centre
9	Haydock Medical Centre
10	Garswood Medical Centre
11	Rainford Health Centre
12	Albion Street Clinic
13	Lowe House
14	Mill Street Medical Centre
15	St Helens Urgent Treatment Centre
16	Fingerpost Medical Centre
17	Jubilee Court
18	Wheelchair Service
19	St Hugh's House
20	Southport Centre for Health & Wellbeing
21	Horton Lodge

3.1 Summary of how we did against our 2024-25 Quality Account objectives

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

No	Objective	Lead Director	Measurement	2024-25 Year End Position
1.	Continue to ensure the timely and effective assessment and care of patients in the Emergency Department.	Chief Operating Officer	All patients requiring triage are either triaged within 15 mins or have a baseline set of observations within 15 minutes based on monthly audits	Triage working groups have been established to develop action plans to drive improvements in the achievement of this national standard. This remains an objective in 2025-26.
			First clinical assessment median time of <2 hours over each 24-hour period	Consistently demonstrated compliance with this measure.
			Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits.	Consistently achieved 85% compliance with this target.
			Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring.	Administration of antibiotics within 1 hour of diagnosis has not been achieved consistently and there are improvement actions that will be implemented in 2025/26, including - • Microbiology to provide a list of all positive blood cultures each week • Clinical Audit Team to develop an in-house Sepsis audit tool • Safety huddles - need for blood cultures within an hour for high risk and within 3 hours for moderate risk patients

No	Objective	Lead Director	Measurement	2024-25 Year End Position
2.	Reduce the incidence of methicillin-resistant Staphylococcus aureus (MRSA) healthcare associated bacteraemia infections to meet the zero-tolerance threshold and a 15% reduction of avoidable hospital onset MSSA bacteraemia	Chief Nursing Officer (CNO)/ Chief Medical Officer (CMO)	Achieve minimum aseptic non-touch technique (ANTT) compliance of 85% for Level 1 (theory) and Level 2 (practical).	• Level 1 achieved. • Level 2 is not recorded on ESR for the legacy Southport and Ormskirk sites but this has been addressed for 2025-26 following implementation of the harmonised ANTT project. The IPC Team engaging with divisional teams and practice educators to promote completion of the practical competency training.
			Achievement of 95% compliance with MRSA screening	MWL MRSA screening compliance was 93.4% during Q3, which is below the Trust target of minimum 95% admission screening for all inpatients. Going forward this will be a metric of focus within divisional governance meetings.
			90% compliance with visual infusion phlebitis monitoring	A monthly PIVC spot check audit is part of the IPC audit plan for 2025-26 to improve cannula care. A target of minimum 90% compliance with VIP monitoring has been set. The IPC Team is supporting divisional leads to strengthen IPC governance and drive improvements in cannula care.
3	Ensure patients in hospital remain hydrated to improve recovery times and reduce the risk of deterioration, kidney injury, delirium and falls.	CNO	Monthly audits on every ward to ensure all patients identified as requiring assistance with hydration have red jugs in place.	Red jugs compliance has continued to improve since Quarter 1 and is over 90% target.
			Monthly audits on every ward to ensure fluid balance charts are up-to-date and completed accurately.	Southport and Ormskirk hospital sites are now digital for fluid balance charts on adult inpatient wards in line with the Whiston, St Helens and Newton hospital sites. A new patient information leaflet has been introduced on the adult inpatient wards for patients able to utilise it.

No	Objective	Lead Director	Measurement	2024-25 Year End Position
			High compliance with Advancing Quality (AQ) AKI (Acute Kidney Injury) audit results	MWL is one of the top three C&M Trusts for performance against the Advancing Quality (AQ) targets for acute kidney injury (AKI) – January 2025 data. AKI pathways continue to be standardised and training on completion of fluid balance charts delivered by the critical care outreach team at Southport Hospital and the AKI team at Whiston Hospital.
4.	Continue to improve the effectiveness of the discharge process for patients and carers.	Chief Operating Officer (COO)	Improved Inpatient Survey satisfaction rates for receiving discharge information.	The latest inpatient survey (2023) showed a decline of scores relating to discharge. This was the first MWL survey and therefore, the results are not directly comparable to previous surveys, however there was an improvement in 6/11 measures compared to the previous Southport and Ormskirk NHST survey.
			Achievement of 20% target for patients discharged before noon during the week.	Ongoing improvement throughout the year. Planned ECIST development for board rounds will support early plans for discharge and ensure engagement improves with discharge lounges in both sites. Golden patients will continue to be identified by the flow teams and bed management teams and ensure wards are supported with booking of transport, blood results and completion of To Take Out (TTOs) medication.
			Proportion of patients who have received the discharge from hospital booklets (audits)	Consistently achieving target.
			Review of discharge data to confirm reason for delay is not due to waits for take home medication (threshold 5%)	This area remains an objective for 2025/26. A key in hospital workstream in the MWL System UEC Improvement Plan for 2025-26 is Improving Discharges. This includes implementing the ECIST recommendation on board and ward round processes and focused work on reducing the length of time taken by TTOs and ensuring TTOs requests are at the pharmacy earlier.

No	Objective	Lead Director	Measurement	2024-25 Year End Position
5	Continue to improve the overall experience for women using the Trust's Maternity Services	CNO	Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys and feedback from women receiving maternity care and delivery of the agreed action plan.	For the 2024 NHS Maternity Survey results MWL scored about the same as other Trusts in 48 questions, somewhat worse for 5 and worse than expected for 4. The results were triangulated with other sources of patient feedback including feedback from Maternity Neonatal Voices Partnership (MNVP) and Trust Safety Champions walkarounds which reflected positive feedback and did not pick up the same themes as the national survey. Patient Advice and Liaison Service (PALS), complaints and FFT feedback was also triangulated with key themes identified around antenatal waiting times, communication (with women and families at various points in the patient journey) and increasing the facilities for partners to stay overnight to offer support following birth, which has been implemented in 2024-25. An action plan has been developed to address the findings of the national survey and shared with Maternity staff. This action plan is monitored monthly at the Women and Children Divisional Meeting. Of the 35 actions, 15 are completed, 17 are on track for delivery by the agreed deadline on track, and 3 are currently amber - as they are linked to the implementation of a new Maternity Information System (Badgernet), which is not due to be implemented until March 2026. The Maternity and Patient Experience teams have developed local surveys to assess the impact of the completed actions and identify other areas of focus ahead of the next national Maternity Survey.
			Create a MWL Maternity Strategy to support delivery of the national three-year maternity plan.	Consultation with staff, service users and stakeholders is underway on the new MWL Maternity Strategy.

3.2 Patient experience and Inclusion

The Trust acknowledges that patient experience is fundamental to quality of healthcare and that a positive experience leads to better outcomes for patients, as well as improved morale for staff. Patient experience is at the heart of the Trust's vision to provide 5 Star Patient Care.

The first MWL Patient Experience Strategy 2025-28 has been developed, reinforcing the Trust's ongoing commitment to improve patient experience. The strategy has been developed in partnership with our patients, key stakeholders, and local communities. Its key commitments and objectives have been informed via patient feedback, concerns and complaints, incidents, the results of National Patient Experience Surveys, national guidance and legislation and the need for further collaboration between hospital sites following the formation of MWL. It sets out the Trust's commitment to improving patient experience by meaningfully engaging with our patients, key stakeholders and local communities to remove any barriers to access, by building on our current engagement activities, and ensuring people from all our local communities are included.

There are three commitments and 14 associated objectives laid out in the strategy that will support a continuous cycle of engagement throughout every step of the patient journey, embodying the Trust values:

- We are kind
- We are open
- We are inclusive

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

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

Patient stories have continued to be shared in multiple formats such as handwritten, digital and filmed. Stories have been collected from a wide variety of areas and have featured maternity care, the smoking cessation service and the acute oncology service. They are shared at the Patient Experience Council and bi-monthly at Trust Board. Stories are presented that demonstrate both positive experiences and those where learning and improvements are required.

Patient Inclusion

Commitment 3 of our Patient Experience Strategy states that we are inclusive and that the Trust will:

- Value everyone's cultural, social and personal needs
- Celebrate our differences and support each other
- Listen to all voices
- Work as a team and learn from each other
- Challenge prejudice and promote acceptance

Including the inclusivity value as an MWL commitment ensures that we actively listen to the voices of all our patients and use the feedback they give us to create and support an environment where everyone's cultural, social and personal needs are valued, and our differences are not only acknowledged but celebrated.

As part of our inclusive commitment, we have set out the following objectives that we aim to achieve:

- Objective 1 – Expand our engagement with local communities to ensure they are consulted promptly when changes to Trust services or estate are planned
- Objective 2 – Improve accessibility across all areas of all sites of MWL
- Objective 3 – Implementation of the NHS reasonable adjustments flag
- Objective 4 – Participate in EDS22
- Objective 5 – Maintain/improve on relevant accreditations

All our objectives aim to improve accessibility and inclusion in all our services for all of our local communities, regardless of a person's background or protected characteristics.

Engagement and consultation

- The Patient Participation Group is held each quarter, with a face-to-face meeting and virtual access for those who cannot travel.
- In summer 2024 we began engagement work with local stakeholders from inclusion heath groups in collaboration with our Healthwatch partners to understand 'What matters to me' for patients when accessing our services, from first point of contact with the Trust right through to being an inpatient or outpatient in one of our hospitals. To date we have engaged with drug and alcohol users, homeless mothers, and veterans.
- Regular updates are given regarding changes to the Trust estate, new services and service development. The group helped to develop our Trust values and priorities for the next year and were actively involved in our EDS22 assessment.

- We continue to engage regularly with our community stakeholders to understand any barriers that they may face when trying to access our services and also to showcase changes we have made, some of which are based on their feedback.
- We have engaged with carers groups to explain the 'carers passport' and the benefits for carers detailed in the document.
- Access audits and PLACE inspections have restarted following the Covid-19 pandemic, and patient representatives from our local communities and local Healthwatch groups have participated alongside Trust staff.
- We have engaged and consulted on policies and standard operating procedures (SOPs) from specialist groups e.g. Trans policies with the Lesbian and Gay Foundation (Rainbow Badge accreditation) and our Proud staff network.

Patient Equality Objectives 2023-27

The following objectives will be the focus for the coming years looking at all areas of the Trust. The focus is not only how accessible the estate is, but also how accessible and inclusive our services are, which includes:

- The Patient Experience and Inclusion (PEI) Team will begin a whole Trust accessibility review, to address all issues around accessibility, communication methods, call signal etc.
- The patient app has now been launched and the feedback we have received so far has been positive.
- Optimising the provision of interpreting services in the Trust.

Equality Delivery System (EDS)

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

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

The 2024-2025 EDS assessment was held on 25 February 2025, and our agreed scores for each service and the overall Domain 1 score are shown below.

During 2024-25 the services studied were:

- Breast reconstruction = scored excelling
- Maternity services = scored excelling
- MSK service = scored achieving

Domain 1: Commissioned and provided services Approved scores 2024-25	
1A: patients (service users) have required levels of access to the service	**EXCELLING**
1B: Individual patients' (service users) health needs are met	**EXCELLING**
1C: When patients (service users) use the service, they are free from harm	**EXCELLING**
1D: Patients (service users) report positive experiences of the service	**EXCELLING**

Veterans Aware

In March 2025 MWL was pleased to announce that Veterans Aware Accreditation had been awarded to the Trust. Feedback from the assessors and programme director included:

> *'Following the Trust's initial accreditation awarded in August 2021 and subsequent accreditation on the merger in Nov 2023 your efforts in continuing to drive the Veterans Aware agenda in your organisation are clearly progressing and making a difference.'*
>
> General Lord Richard Dannett,
> GCB, CBE, MC, CB, DL
> Patron of Veterans Covenant Healthcare Alliance

The eight manifesto requirements assessed and successfully met were:

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

3.3 Friends and Family Test (FFT)

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

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

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

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

You Said	We Did
Lack of resources for activity and entertainment. **(Ward 1 Southport Hospital)**	Charitable funds application submitted and approved for resources to support activity and socialisation. Including table and chairs, DVD player and radio.
Lack of bereavement support following a death out of hours in the theatre department. **(Theatre Department – Southport Hospital)**	Department bereavement box reviewed. Out-of-date information removed and replaced with new booklets. Bereavement property bags now in place along with contact information for the Spiritual Care and Chaplaincy team.
'Discharged with no explanation of what had previously happened or any plan going forward' **(Ward 7a – Southport Hospital).**	Doctors to ensure medical plans are discussed prior to discharge. Discharge summaries to include treatment and ongoing plans. Details of actions taken following feedback are displayed on the ward information noticeboard to patients and their families.
Incorrect meal order in line with religious and cultural needs. **(Regional Spinal Injuries Unit – Southport Hospital)**	Individual meal ordering processes were audited, and the outcome was shared with family and staff. Patient needs are now included in handovers and safety huddles, and also highlighted within the care plan.
A need for more antenatal information. **(Maternity and Maternity Neonatal Voices Partnership - Ormskirk DGH)**	A virtual listening event was introduced: 'An evening with your local obstetrician'.
Long wait in reception before procedure and long wait in ward after waiting discharge. Would like to have been told long waits possible, this would have made the waiting easier. **Plastic Surgery Day Unit**	"Thank you for your feedback, waiting times have unfortunately increased recently due to extra theatre activity. We will be creating a poster to advise patients of potential long waits during busy periods and will endeavour to keep patients up to date on how long they can be expected to wait in the future."

You Said	We Did
Appointment was very poor. Clinician I seen did not introduce herself, so I am unsure what role she had/ if she was a consultant etc. She was very rude and dismissive as if I was wasting her time. I was sent for an ultrasound and again no introductions were made and the lady performing ultrasound was also very rude and did not close the door to the room when performing ultrasound on my breast. I was made to feel I should not have been given an appointment. I was sent back outside to wait and then waited almost 2 hours for the results of the ultrasound. I appreciate these things take time. **Burney Breast Unit, St Helens Hospital**	"We are sorry to hear about your recent experience. We understand how stressful attending an appointment is. I have shared your experience with our clinicians and radiology team, we will be discussing this matter and reviewing our patient flow and if there are things that can be added to improve our service. I will also share this with the nursing team to make them aware of privacy and dignity is maintained."
Great service by staff but the heat and lack of fresh air as the windows are locked is horrendous. It made me so uncomfortable. **(Ward 3A – Whiston Hospital)**	Unfortunately, the windows were locked by our Estates and Facilities Team for a short period due to a safety issue; this is now rectified and all patient windows are able to be opened.
I thought that the staff are nice, service poor, food very cold all the time. **(Newton Inpatients)**	Review with catering regarding how food temperature checks are performed. Each meal is checked for correct temperature and only four meals are given out at a time to make sure correct temperature is maintained. Only 3 microwaves are currently in use. A new microwave has been ordered to ensure meals are given out in a timely manner.

3.4 Complaints

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

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

Regrettably, sometimes patients or their carers may wish to raise a formal complaint. These are thoroughly investigated and afterwards complainants are provided with a comprehensive written response. Complaints leaflets are available across the Trust and information on how to make a complaint is also available on the Trust website. MWL has a current target to respond to formal complaints within 60 working days, where appropriate.

MWL complaint figures for 2023/24 and 2024/25 are detailed in the below table:

	2023/24	2024/24 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	Total 2024/25
MWL – First stage complaint	420	109	122	144	142	517
Response Compliance % Trust Target 80%	63.16%	74.76%	57.44%	62.9%	64.6%	64.22%

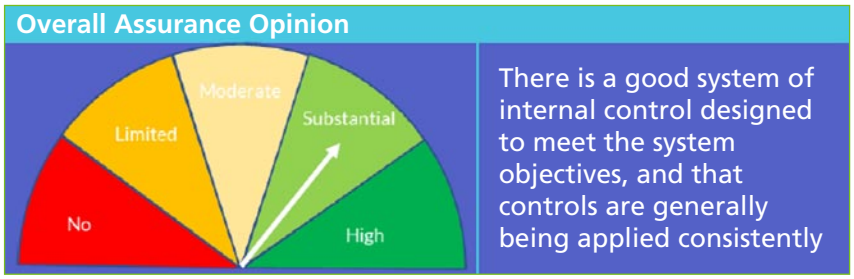
In 2024-25 the Trust received 517 new complaints. This is an increase to the previous year during which the Trust received 420 new complaints.

During 2024-25 the Trust has received 39 complaints back for stage 2 further investigation. This is a decrease of 19% in comparison to the previous year when the Trust received 48 complaints.

MWL has achieved total compliance of 64.22% against the timescale of 60 working days during 2024-25. Significant work has been undertaken by key staff at the Trust who are committed to reducing the time taken to respond to complaints, including the appointment of a dedicated Head of Complaints, recirculation of the guidance on drafting and quality checking of statements and complaint responses, training on statement writing to new divisions, and discussions with divisions about appropriate resources for complaints within their new structures. A particular focus on early resolution meetings has also proved successful.

MIAA – Complaints Management Review Audit

The Trust has received an overall assurance opinion of substantial following the audit conducted by Merseyside Internal Audit Agency (MIAA) in October 2024. There is a good system of internal control designed to meet the system objectives, and controls are generally being applied consistently.



Lessons Learned

The Trust is committed to learning lessons from complaints, ensuring robust actions are put in place and monitored, and that accountability is clear. This is to offer assurance to the complainant and to prevent a similar issue from occurring again.

Below are some of the key lessons and changes from the last financial year:

Improve communication with patients and their families regarding discharge planning, including on-the-day discharge communications

- Engagement with medical and nursing teams to ensure that staff are aware that discharge booklets are to be given out to patients from admission. Allocation of a champion for the area to promote this.
- Clear documentation when conversations have taken place through reminder at Safety Huddles across all wards.
- Documentation to record that updates have been provided to patients and their nominated next of kin regarding progress and discharge planning, promoted through reminders at daily Red to Green (R2G) meetings.

Ward Manager to be present on the daily board rounds ensuring routine discussion of mobility/therapy requirements

- Ward Managers to undertake education with nursing teams at ward level to ensure there is clarity around requirements for referral and the process to ensure all patients are referred appropriately and staff have a good understanding of this.

Pre-discharge actions

- Pharmacy will review whether to amend guidance for patients who have swallowing difficulties.
- Pharmacy will provide 'lessons learned' bulletin for dispensary staff to escalate items which are out of stock to a pharmacist as the earliest opportunity.
- Pharmacy to consider expanding ward-based Pharmacy Technician service to support with discharges.

Difficulty contacting named midwife

- The Community Midwives now have a voicemail message on their mobile telephones reiterating that these numbers are not to be used in an emergency. Alternative details are given of who to contact in the event of an emergency. Additional information can be added advising what day they are next on duty and the number to contact in a non-emergency, if the caller wishes to speak with someone sooner.

Ensure discharge process is robust and that patients are being given clear guidance and safety-netting post procedure

- Hold discussions at departmental meetings to gain an understanding of what staff feel are the expectations of discharge conversations, and to ascertain if this process needs reviewing to establish a better process.
- Reiterate to staff the importance of documenting what discussions have been held and evidencing this in health records.

3.5 Our volunteers

Volunteers make a unique and valuable contribution to patients and carers, relatives, visitors, and staff. MWL is extremely grateful for the time, skills and support our volunteers offer and recognises the positive impact this makes for people who use our services, including our staff, and the wider community. Volunteering can significantly benefit individuals who choose to give up their time to help others and it is recognised as a means for promoting healthy populations and improving public health. Volunteers are visible and seen as a fundamental part of MWL, complementing our workforce and contributing to a better experience for our people.

A total of 377 volunteers completed 2–4 hours of volunteering each week.

Volunteers can choose from 28 different roles across 5 hospitals.

205 volunteers were recruited in 2024 across 5 hospitals.

Our roles

Butterfly Volunteers

The Butterfly Volunteer Project was launched in June 2024 in partnership with the Anne Robson Trust, with the aim of providing companionship to patients identified as being in the last days and hours of life. Referrals are made by our Specialist Palliative Care Team who can then ensure volunteers have relevant information and support. We currently have 14 volunteers with further applications being received on a regular basis.

Butterfly Volunteers enable patients and those important to them to share their story, offering a listening ear and comfort to reduce anxiety and isolation. Butterfly volunteers will alert staff if patients require support such as mouthcare, pain relief or re-positioning and staff have welcomed the reassurance of knowing that a volunteer is present to support patients who may otherwise die alone.

The Volunteer service was successful in acquiring charitable funds to purchase resources for volunteers to use during visits such as sensory lights and music to create a calming, pleasant environment. This has been well received by patients, visitors and staff. In addition, we offer knitted hearts and butterflies to patients and visitors to create connection and positive memories.

Relatives have commented that our service has been a *"beacon of light in a dark world"* and have also welcomed the opportunity to be offered respite. They are kept updated on relevant services within the Trust that may improve their experience.

During the first six months of service, the team has completed 500 visits, providing approximately 350 hours of support to 639 people (163 patients and 476 visitors)

Plans are being explored to extend the service across Southport and Ormskirk hospitals in the near future.

Discharge Support

The discharge support service continues to operate Monday to Friday and supports patients 48 hours post-discharge via telephone.

Sefton CVS referral feedback

'I just wanted to offer you some feedback following on from your referral for this very lovely couple (Mr & Mrs B). I have now closed the case with our service, after providing welfare visits and calls, supporting with AA forms and Blue Badge applications. I have also carried out a T/A assessment and ordered aids and adaptions for the bathrooms and supported A to review the current level of support and to provide additional care hours each day.

Carers are going in each morning and additional hours built in four afternoons a week to give Mrs B sometime to herself. They expressed their gratitude for the referral to our service and would like to pass this on to your team.'

Dining Companions

We currently have 13 active dining companions across Whiston and Southport hospitals. In 2025 we will be focusing on increasing the number of dining companions as they play a crucial role in the hospital; supporting and encouraging patients to eat and drink and therefore helping to reduce the risk of malnutrition and dehydration. Staff are very appreciative of this service and their feedback is very positive. We have 4 training dates set for 2025 to increase numbers for this service.

Voice of the Volunteer

Volunteers who leave are asked to complete an Exit Questionnaire so that we are able to collect feedback on their experience. The data shows that 100% of leavers would recommend the Trust to other people who are interested in volunteering.

> Volunteering provided insights on my career path, gave me self confidence and helped to enhance and develop new valuable skills.

> The best thing about volunteering was knowing you were helping the patients and visitors. I met new friends and became more confident. I felt supported and I really enjoyed volunteering.

> A fantastic organisation! All staff are friendly, kind and welcoming. I got to use a wide range of skills, I loved how the role felt very rewarding, and staff and patients appreciated me. I had a great time volunteering.

Volunteers into Work

Lauren - Midwife 	At 16 I had my first interview to become a volunteer! Volunteering was the start of my midwifery journey; I will always be grateful to have had the opportunity to learn and grow before applying to university. I developed my confidence, communication and social skills making me evolve into a confident young adult who was comfortable conversing with everyone, a skill very necessary in midwifery. I achieved my A levels and started university in 2020. Midwifery is a calling, and I feel very honoured to be able to say from being a volunteer at 16, I am now a midwife at MWL at the age of 22 having delivered 40 babies!
Katy – Sonographer 	After gaining my Masters in Public Health, it was always my plan to work within healthcare. I managed to secure a couple of interviews, but I lacked hospital experience, so I was not considered. I signed up as a volunteer to gain more experience which led to a role as a healthcare assistant at Ormskirk. I learnt so much about the hospital and the NHS in general, which really helped me with my interview questions. Most importantly, I was able to use so many examples of interactions I had with patients which demonstrated my ability to work under pressure, with difficult scenarios and situations. As a result, I got the job! I know that this would never have been possible without volunteering, and I would not be in such an amazing job without it."

3.6 Patient safety

MWL continues to embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience.

The Trust introduced the Patient Safety Incident Response Framework (PSIRF) in Autumn 2023 and has progressed with improving how the organisation responds to patient safety incidents (PSIs). The framework further improves a safety management system that embeds the key principles of patient safety culture, with a focus on understanding how incidents occur and how we can effectively make sense of and learn from them. The Trust has introduced a variety of tools and techniques to carry out reviews of incidents and identify learning.

The Trust has reviewed and refreshed the Patient Safety Incident Response Framework Plan (PSIRP) and revised for 2024-26, which sets out the Trust's approach to the way that patient safety incidents are responded to and how patient safety investigations are undertaken.

3.6.1 Falls

The Falls Team continues to develop strategies to minimise the occurrence of inpatient falls and MWL's falls per 1000 bed days for 2024-25 was 6.256. This is a newly combined figure for MWL.

The Trust continued to implement the Falls Prevention Strategy 2022-25 with a focus on 5 key areas for improvement:

- Embedding a culture of safety improvement that reduces harm caused by falls
- Improving communication of patient risk factors between wards/areas and the Falls Team
- Providing assurance of improvements and learning
- Education and development
- Equipment and environment

The Trust Falls team has continuously provided staff with support, education and guidance to ensure the strategy's action plan is completed within the specified timeframes.

The Trust implemented a decaffeinated hot beverages trial for patients on six wards across the Trust - decaffeinated drinks were offered as the first line option for patients, to reduce bladder irritability and urgency. Positive feedback was received from patients. The Trust plans to roll out decaffeinated drinks across all of our sites by 2026.

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

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

3.6.2 Pressure ulcers

The Trust has continued to focus on reducing the risk of patients developing hospital acquired pressure ulcers due to any lapses in care. There have been no category 3 or 4 cases.

The Trust-wide action plan highlights the main activities implemented in year to improve performance and improvements have been noted in several areas including: documentation, compliance with policy, and engagement in education and training, which the team offers at ward level. A harmonised pressure ulcer risk assessment tool has been introduced across all sites.

3.6.3 Venous Thromboembolism (VTE)

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

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

National reporting for VTE risk assessment compliance was recommenced in 2024/25 after a pause following the Covid-19 outbreak.

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

- Electronic VTE risk assessments are live on the Careflow narrative system
- Paper document is integrated into the acute assessment medical pro forma making a documented VTE risk assessment available for acute admissions
- VTE risk assessment is recorded on patient flow boards with a distinct purple circle assisting ward staff to identify patient status at a glance
- Sharing risk assessment compliance through daily dashboards
- Undertaking an investigation of all cases of hospital acquired thrombosis to reduce the risk of reoccurrence
- Ongoing VTE training including Moodle-based online learning for all clinical staff
- Face to face training for new starters to the Trust

3.6.4 Sepsis

Improving early identification of patients with Sepsis is a key patient safety and quality objective. To tackle ongoing antibiotic compliance, the Sepsis Team and Critical Care Outreach Team (CCOT) are initiating a service improvement project in 2025-26 to work collaboratively with medics from the Emergency Department to improve the prescription to administration time for patients deemed high/moderate risk in line with new NICE Sepsis guidance. This will be audited in 2025-26 to monitor any improvements. Our Sepsis Clinical Leads are also working with the Clinical Audit Team to create an MWL inhouse audit using AMaT that will enable monthly review of sepsis patients across the Trust.

3.6.5 Medicine safety

The Pharmacy department has continued to focus on medicine safety, with a number of actions taken as outlined below.

Electronic Prescribing and Medicines Administration (ePMA)

There has been an ongoing programme of ePMA system development and rollout overseen by the project board. In 2023-24, the Spinal Unit at Southport went live with ePMA, and further roll out across the rest of the Southport and Ormskirk hospital sites is anticipated to be in the second half of 2025. Discharge processes remain disconnected from the ePMA system requiring a manual process to produce discharge letters. In addition to the Southport rollout, work has been undertaken to install ePMA in the Intensive Care Unit at Whiston Hospital - the potential to utilise ePMA in maternity and paediatrics at Whiston Hospital has been raised.

Chemocare

The electronic prescribing system is now Trust-wide supporting effective monitoring of our chemotherapy workload, which is dispensed through our Aseptic Units at both Southport and Whiston hospitals. This activity continues to increase as medication protocols develop in sophistication.

Pharmacy dashboard (at Whiston, St Helens and Newton sites, and Southport Spinal Unit - linked to ePMA)

During 2024-25, the pharmacy dashboard continued to be developed. It is an invaluable 'live' resource which enables clinical pharmacy staff to review the medicines status of patients on each ward at a glance and prioritise their workload. This takes feeds from multiple systems including ePMA, laboratory results, alerts, and the dispensary systems.

In addition to the dashboard, the pharmacy service is now able to track discharge turnaround times more efficiently for both legacy Trusts, displaying data in an equivalent manner despite it pulling from two different IT systems.

Medicines audits

Focus on standardisation of safe and secure handling medicines and controlled drug audits across MWL, recorded in Tendable, reports to Medicines Safety / Controlled Drugs oversight groups and Patient Safety Council.

Audits remain ongoing and continued improvement in performance has been reported from the previous year. Targeted improvement work has been provided to areas identified as requiring support in the audits. Ward-based pharmacy technicians now also perform weekly audits on safety and security of medicines on wards. Feedback is given to the ward manager and escalated to the matrons and an action plan is put in place if improvement is not made.

Policy Alignment

During the year, notable work has been completed to update MWL Patient Group Directive (PGD) policy, Controlled Drug Policy, Medicines Optimisation Policy, Potassium Policy and Cannabis Policy.

Currently reviewing self-administration, discretionary medicines, covert administration, outpatient antibiotic therapy and paediatric antimicrobial policies.

Medicines Safety

The Medicines Safety team continues to provide an exemplary service to the Trust with highlights including:

- Monthly input into the Trust's safety huddles and Trust's 5 Star accreditation process.
- Cross site medicines safety bulletins, with MWL branding to inform staff on issues such as safe paracetamol dosing, Eezy CD rulers to enable accurate checks of Controlled Drug liquids, 5R's and management of shortages of critical medicines (e.g. IV vitamins, potassium liquid).
- Critical medicines guidance cards updated for use across MWL.
- Contribution to Safety Summit Week (Cultural Change podcast and demonstration of the drug library).
- Contribution to investigation of serious incidents, pharmacy representation at weekly patient safety panel and the monthly patient safety council.
- Ongoing work to review NHS England's (NHSE) enduring standards to benchmark and align processes across MWL.
- Process for pharmacy oversight of MHRA medicines recalls and assurance these are dealt with in a timely manner.
- Compliance with national recommendations for Antidotes in emergency departments across MWL (Whiston, Southport and Ormskirk sites).
- Work with Risk department regarding timely management of NatPSA alerts.
- An IV access group has been set up to oversee issues related to cannulation, aseptic preparation of IV drugs, critical drug monographs and development of drug library (to make IV drug administration safer).
- Leading on work to standardise single patient information leaflet and written consent for IV iron administration, in all clinical indications following several incidents.
- Ongoing work on nurses' link group (Whiston and St Helens hospital sites), with plans to extend to Southport and Ormskirk hospital sites.
- Continuing work to standardise Controlled Drug processes for pharmacy and wards across MWL.

Clinical

The Pharmacy Clinical Service operates as two distinct services pending the introduction of a harmonised EPR/EPMA solution for MWL. Wherever possible, the aim is to support clinical services with a "do it once" methodology across all sites with some significant developments over 2024-25 and further harmonisation plans for 2025-26 regarding divisional support:

- Discharge medicines service to prompt follow-up of patients by community pharmacists is performing well.
- Falls and AKI reviews of patients by clinical pharmacists.
- Specialist inpatient diabetes and pain reviews (Southport only) are embedded in practice.
- Consultant pharmacist and other pharmacist colleagues providing input to frailty and virtual wards.
- Joint MWL posts active e.g. AKI, HIV pharmacists.
- Antibiotics - EOLAS (a guideline portal for antibiotic guidance) rolled out; hosts MWL anti-microbial policy.
- Active pharmacist involvement in antimicrobial stewardship programme on both acute sites.
- Review of clinical service to Women's and Children's services are underway, aiming to install professional pharmacy leadership within the division.

Emergency Department (ED) developments

The ED pharmacy teams are now well embedded in the multi-disciplinary team (MDT) but continue to come under increased pressure. The pharmacy staffing model is under review.

The storage of individual patients' medicines in ED has also been reviewed and there is a plan to support the safe storage of medicines. At Southport and Ormskirk hospitals, bedside lockers are in place in ED, the Ambulatory Care Unit and the Clinical Decision Unit.

Pharmacy

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

- Pharmacy Technician leadership structure has been adjusted to introduce a MWL Chief Pharmacy Technician to our team who will help with the journey of harmonising the MWL Pharmacy team.
- Automatic labelling process started at Whiston site for inpatient dispensing activity to increase efficiency of the dispensary. There has been an associated improvement in discharge turnaround times.
- Merging Medicines Information service to be based primarily at Ormskirk site by Summer 2025.
- New pharmacy robot installed at Ormskirk site with capital bid and plans for new robot at Southport site.
- Increased pharmacy technician presence on wards at Southport and Ormskirk hospitals aligning the service with the Whiston and St Helens sites.
- Merged Pharmacy audit meeting is now operational and tracking the Pharmacy specific audit plans through AMaT clinical assurance software.
- Single EPRR action card developed for MWL pharmacy sites.
- Risk registers rationalised and moved to singular MWL Pharmacy InPhase Risk Register.
- MWL Pharmacy SOP alignment continues to progress alongside Policy harmonisation.
- Approval for additional trainee pharmacy technician at Southport from NHSE.
- Homecare staffing monies have been awarded from the ICS and NHSE to support the High-Cost Drugs agenda.

3.6.6 Infection prevention

The Health and Social Care Act 2008 requires trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infections (HCAI). The Director of Nursing, Midwifery and Governance (now known as Chief Nursing Officer) was previously the Trust's Director of Infection Prevention and Control (DIPC), with Board level responsibility for infection control.

The position of a designated Director of Infection Prevention and Control (DIPC) was formally appointed to in January 2025.

The Trust's infection prevention priorities are to:

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

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

The NHS Standard Contract for 2024-25 outlines the reportable healthcare associated infections, and the combined threshold for the Trust is as follows.

- C. difficile </=113
- E coli </=171
- Klebsiella </=49
- Pseudomonas </=16
- Zero tolerance to MRSA bloodstream infection

MRSA bacteraemia

A zero-tolerance approach is still in place to support no MRSA bloodstream infection. There were a total of six cases in year: 4 cases at the Whiston Hospital site and 1 case each at the Southport and Ormskirk hospital sites. Two cases were deemed unavoidable following post infection review panel, one case is awaiting panel review, and the other cases had organisational lessons for improvement identified.

Case	Date	Attribution	Dept	Site	Source	Avoidable
1	22/06/24	HOHA	ED	Whiston	Cannula	Yes
2	27/09/24	COHA	Maternity Ward	Ormskirk	Episiotomy	No
3	05/10/24	HOHA	Spinal Injuries Unit	Southport	Sacral wound	Yes
4	04/11/24	HOHA	Ward 4B	Whiston	Hand wound	Potentially
5	30/12/24	HOHA	Bevan Ct 2	Whiston	Deep source	No
6	25/02/25	COHA	Ward 2A	Whiston	TBC	TBC

Clostridioides difficile (CDI)

The Trust combined NHSE threshold for C.difficile was for no more than 113 cases of hospital associated C. difficile in 2024-25. At year end there were 114 cases (87 HOHA, 27 COHA), one case above the Trust threshold for 2024-25, but one case below the outturn for 2023-24.

In the most recent comparative UKHSA data available, for Quarter 4, the MWL rate of 28.6 per 100,000 bed days is below the Cheshire & Merseyside (C&M) rate of 31.4. MWL and the legacy Trusts have been below the C&M rate for the last four quarters.

The C.difficile Improvement Plan remains on track, incorporating the key elements of environmental cleanliness, appropriate antimicrobial prescribing, and staff awareness and training. Hydrogen peroxide vapour is now routinely used for terminal cleaning following cases of CDI across the three main sites. Although scoping took place regarding a preventative bay-by-bay deep clean programme, deep cleans are being undertaken reactively following outbreaks or incidents and approximately 22 wards across MWL were deep cleaned in year.

The Consultant Nurse IPC represents the Trust at the Cheshire and Mersey IPC Provider Collaborative (CMAST). The first improvement project was completed in Quarter 3, with the development of a C. difficile Toolkit, which includes standardisation of the approach to diarrhoea management and testing, cleaning and Antimicrobial Stewardship (AMS). The toolkit will be implemented at MWL in Quarter 1.

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

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

E. coli

The E. coli NHSE threshold for MWL was for no more than 171 cases. The Trust is below the NHSE threshold by 12 cases, with 158 cases at year end.

The implementation of an E. coli bloodstream infection (BSI) improvement plan, with a focus on hydration and urinary catheter care resulted in the Trust being below the Cheshire and Merseyside rate for the last four quarters. In Quarter 4 the MWL rate of 30.4 per 100,000 bed days is below the Cheshire and Merseyside rate of 33.8. The E. coli Improvement Plan was closed in Quarter 3 as all actions were completed.

Klebsiella

There have been 47 cases against an objective of no more than 49 cases in 2025-26. The Trust is below the NHSE threshold by 2 cases.

Pseudomonas

There have been 14 cases against an objective of no more than 16 cases in 2025-26. The Trust is below the NHSE threshold by 2 cases.

Further achievements for 2024-25 included:

The Infection Prevention Team works collaboratively across the new MWL Trust, with a focus on harmonising policies and guidance to ensure standardised and reliable IPC practice.

The revised Infection Prevention Learning Review (IPLR) process has been embedded across all sites for hospital-associated CDT cases, and MSSA, E. coli, Klebsiella and Pseudomonas HOHA bloodstream infections. The aim is to support the PSIRF principles and to assist with thematic review across MWL, to identify further areas for improvement regarding healthcare-associated infections.

As part of the MWL Mandatory Training project, ANTT has now been harmonised with alignment of the delivery model, frequency and staff groups who require training.

Proactively responded to the endemic and emerging infections e.g. mpox, tuberculosis and measles, ensuring appropriate surveillance and management of the patients presenting to the Trust.

The IPC Team plays a key supportive role in the Trust's clinical accreditation programme.

The IPC Team supports a network of IPC link practitioners and delivers regular education sessions and study days to develop their knowledge and skills.

Improved engagement with ward leaders to optimise the clinical environment for patients, with a programme of 'estates walkarounds', with the Estates Team and the IPC Team Matron.

Support from the IPC Team on the extensive capital estates projects, to improve the built environment for patients and staff across MWL.

The IPC Team continues to work closely with Trust sustainability leads and Procurement to seek further efficiencies, both financially and in terms of driving the sustainability agenda e.g. improving waste streaming and standardising hand hygiene and cleaning products.

3.6.7 Being Open – Duty of Candour (DOC)

The Trust is committed to ensuring that we tell our patients and their families/carers if there has been an error or omission resulting in harm. This duty of candour is a legal duty for Trusts to inform and apologise to patients if there have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).

The Trust promotes a culture of openness, honesty and transparency. Our statutory duty of candour is delivered under the Trust's Being Open - A Duty of Candour Policy, which sets out our commitment to being open when communicating with patients, their relatives and carers about any failure in care or treatment. This includes an apology and a full explanation of what happened with all the available facts. The Trust operates a learning culture, within which all staff feel confident to raise concerns when risks are identified and then to contribute fully to the investigation process in the knowledge that learning from harm and the prevention of future harm are the organisation's key priorities.

The Trust's incident reporting system has a mandatory section to record duty of candour. Weekly incident review meetings are held, where duty of candour requirements are reviewed on a case-by-case basis allowing timely action and monitoring. This ensures the Trust meets its legal obligations.

The Trust has continued to raise the profile of duty of candour through the lessons learned processes and incident review meetings. In addition, duty of candour training is included as part of mandatory training and investigation training for staff.

3.6.8 Never events

Never events are described as serious incidents that are wholly preventable by NHS England in the 2018 framework. Each never event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a never event.

The Trust remains committed to understanding the cause of these incidents through comprehensive investigation. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and to feed back in the knowledge that the issues will be fairly investigated, and that any learning and improvement opportunities will be implemented.

The Trust reported five never events in 2024-25, which met the criteria.

Retained guidewire	Low harm
Wrong site steroid injection	Low harm
Wrong site surgery	Moderate harm
Wrong site nerve block	Low harm
Retained foreign object	Moderate harm

The Trust has also extended its focus on learning from never events to a targeted approach on improving processes in theatres and other clinical environments where invasive procedures are performed. This has led to the formation of the Invasive Procedures Working Group which endeavours to improve safety by reviewing current best practice whilst taking into account the principles of NatSSIPS2. The group has senior clinical leadership representative and is underpinned by QI methodology. The key drivers for this area of improvement are the recent never events and the learning identified following investigation.

Learning from these incidents was identified using Systems Engineering Initiative in Patient Safety (SEIPS) methodology to minimise chances of such an incident happening again in the future. This methodology is part of the national PSIRF toolkit and is a well-recognised and endorsed system-based model.

A number of actions were identified and implemented. These include reviewing and updating the policy for the Local Safety Standards for Invasive Procedures (LocSSIP) and local safety checklists, and enhancing the pause/stop moment for local anaesthetic procedures. Further learning which will require focus going forward is in regard to distractions in the theatre environment during the safety critical stages of surgery.

3.6.9 Theatre safety

The Trust Operating Theatre Department continues to develop and refine patient safety initiatives in keeping with the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs), to reduce the number of patient safety incidents related to invasive procedures.

The department has reported 3 incidents meeting Never Event criteria in 2024-25, with immediate actions taken to reduce the risk of further incidents. This relates to an incident of retained guidewire, an incident of wrong site surgery, and an incident of wrong site nerve block. There has not been any identified long-term harm to the affected patients as a result of these incidents.

All incidents have been subject to an in-depth Patient Safety Incident Investigation (PSII) in accordance with the Patient Safety Incident Response Framework (PSIRF). Careful evaluation of systems and pathways using Systems Engineering Initiative in Patient Safety (SEIPS) has been undertaken. The methodology helps develop insight into a process or problem, drilling down deeper into individual tasks or processes in more detail. Theatre safety checking process and surgical safety checklists continue to evolve in response to learning from incidents and other improvement work. The department has focused upon initiating several actions within the patient pathways.

3.6.10 Safeguarding

The Trust is committed to ensuring safeguarding responsibilities are carried out in line with legislation and national and local policy. There are dedicated Safeguarding Teams situated on different Trust sites. Within these teams there are Named Nurses and Named Midwifes for both children and adults supported by specialist safeguarding practitioners. Assistant Directors support the Director of Nursing, Midwifery and Governance to ensure that the Trust is fulfilling its statutory safeguarding responsibilities.

A suite of safeguarding policies have been harmonised following the joining of the legacy St Helens and Knowsley and Southport and Ormskirk hospital trusts, along with associated robust processes to protect unborn infants, children and young people and adults at risk (including those with a diagnosis of a learning disability and/or autism) from harm or abuse. In addition, there is a specific Safeguarding Training Needs Analysis which identifies the level of training every staff member within the organisation must complete, including safeguarding adult and children training, mental capacity, Prevent, and learning disability awareness. The Safeguarding Team also ensures there are processes in place to support patients who are unable to consent to care and treatment and require a formal capacity assessment and completion of an urgent Deprivation of Liberty Safeguard (DoLS) authorisation - these are quality assured and processed by the Safeguarding Teams.

The Safeguarding Teams maintain a visible presence across Trust sites and are available to offer advice, support and supervision to all staff. The Trust safeguarding key performance indicators (KPIs) are submitted on a quarterly basis and quality assured by the Integrated Care Board (ICB) Designated Nursing Team (St Helens and Sefton Places). During 2023-24, a red/amber/green (RAG) rating of green was given in all areas except safeguarding training compliance and completion of Looked After Children (LAC) initial health assessments within the St Helens-based Developmental Paediatric Service. There has been a steady increase in training compliance, with the 90% required compliance achieved in the majority of all levels.

The expectation in relation to initial health assessments for LAC (Looked After Children) is that 100% of children will receive their assessment within 20 days of entering the care system; this continues to prove challenging due to both internal and external pressures, including late notifications from the Local Authority, children not being brought to appointments and an increase in the numbers of children requiring assessments. The Developmental Paediatric Team has taken steps to increase appointment capacity and provide weekend appointments to support attendance, as well as working with community partners to review processes and consider any potential barriers.

The ICB continue to confirm assurance in relation to safeguarding activity which has risen consistently across all areas, particularly numbers of referrals and evidence of good multi-agency working. Quarterly safeguarding reports and an annual report are presented to the Quality Committee and a safeguarding report is presented quarterly to the Clinical and Quality meeting for each Division.

The Trust provides representation at five local safeguarding partnership boards for adults and children, and to associated subgroups. When required there is additional representation and contribution to adult and children multi-agency reviews, domestic abuse-related death reviews (previously known as Domestic Homicide Reviews) and theme specific multi-agency audits.

There has been further external scrutiny by way of a Mersey Internal Audit Agency (MIAA) safeguarding audit. This was a positive report with a rating of substantial assurance with elements of high assurance. The medium/low level recommendations will be implemented as per the Safeguarding Action Plan.

3.7 National Staff Survey

The National Staff Survey provides a key measure of the experiences of Trust staff, with the findings used to reinforce good practice and to identify any areas for improvement. For the 2024 survey, reported in 2025, the Trust conducted a full census staff survey. 3944 completed questionnaires were returned giving a 37% response rate.

Eligibility to participate in the NHS Staff Survey continues to include Bank workers in NHS organisations, using a tailored version of an online questionnaire. Eligibility was based on Bank workers who had worked in the six months between 1 March 2024 and 1 September 2024 and who did not have a substantive or fixed term contract. Out of the 1223 people the survey was sent to, 145 people responded providing a response rate of 11.9%.

We are able to make comparisons with the Trust's benchmarking group, which comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure. The Trust's benchmarking group comprises 122 organisations under the heading 'Acute and Acute & Community Trusts' although this does include a couple of specialist children's hospitals such as Alder Hey.

The survey questions remain related to the themes and sub-themes of the NHS People Promise with additional themes of staff engagement and morale retained from earlier surveys. The results give a wide picture of satisfaction across the whole organisation.

Results are reported both as individual question responses and as themes, aligned to the NHS People Promise which are:

- We are a team
- We are always learning
- We are compassionate and inclusive
- We are recognised and rewarded
- We are safe and healthy
- We each have a voice that counts
- We work flexibly

In addition there are the two recurring themes:

- Morale
- Staff engagement

The results for MWL against the best/worst/average for our comparator group are shown in the chart below: *Scores are out of a scale of 10 with 10 being the best.*

	MWL	Best Result	Average	Worst result	
We are compassionate and inclusive	7.37	7.69	7.21.	6.61	Above Average
We are recognised and rewarded	5.95	6.30	5.92	5.24	Above Average
We each have a voice that counts	6.77	7.14	6.67	5.95	Above Average
We are staff and healthy	6.28	6.53	6.09	5.54	Above Average
We are always learning	5.61	6.09	5.64	4.76	Above Average
We work flexibly	5.98	6.86	6.24	5.60	Above Average
We are a team	6.74	7.12	6.74	6.26	Average
Staff Engagement	6.94	7.39	6.84	5.98	Above Average
Morale	6.08	6.38	5.93	5.13	Above Average
Motivation	7.03	7.33	6.98	6.49	Above Average
Involvement	6.79	7.27	6.83	6.20	Below Average
Advocacy	7.03	7.90	6.70	5.24	Above Average

Staff Engagement is calculated as an average from the scores of the following three sub-themes: motivation, involvement and advocacy. MWL performed above the national average for all but one sub theme within this sector, involvement.

Results from the NHS Staff Survey have been disseminated to service leads, managers, and subject matter experts. Plans are currently being developed to implement improvements based on the feedback received. Additionally, Staff Survey Team Talks, led by the CEO, have been scheduled at each site to engage with staff and discuss the implications of the survey results.

3.8 Equality, Diversity and Inclusion (EDI)

The Trust remains committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedoms. Equality and human rights are at the core of our beliefs and the Trust strives to ensure that people with protected characteristics, as defined by the Equality Act 2010, and those individuals from traditionally underserved groups are not disadvantaged when accessing the services that the Trust provides.

The Trust's EDI Steering Group meets regularly to ensure compliance with all external standards, including those statutory requirements conferred on the Trust by the Equality Act 2010. The membership of the group is drawn from a wide range of staff from all disciplines, clinical, non-clinical, trade union representatives, Healthwatch representatives and members of the Trust staff networks.

The Trust is a member of the following external charter marks, accreditations and commitments, which are used to further our equality strategy:

- Armed Forces Covenant (re-signed 2023)
- Defence Employer Recognition Scheme (Armed Forces, gold accreditation 2020)
- Disability Confident Scheme, Leader (Level 3, reaccredited 2023)
- Dying to Work Charter (member, 2023)
- NHS Rainbow Badge Accreditation (LGBT) (Bronze, accredited 2022)
- NHS Sexual Safety Charter (member, 2023)
- Veterans Aware (Armed Forces, reaccredited 2023)
- North West region Stroke Voices

The Trust is a member of the North West Black, Asian and Minority Ethnic (BAME) Assembly and is working towards applying for the North West Anti-Racism Framework accreditation.

3.9 Summary of national patient surveys reported in 2024-25

The national patient survey programme is run by the Care Quality Commission to gather data on patient feedback on patient experiences in healthcare settings. It aims to identify areas for improvement in care and treatment across the NHS. The surveys cover various aspects of the patient journey including access to services and treatment experiences.

National Inpatient Survey 2024	Awaiting publication of report: Aug 2025
National Maternity Survey 2024	Published November 2024
National cancer patient experience survey 2024	Awaiting publication of report: June 2025
National general practice GP patient survey 2024	Published July 2024
National Children and Young Peoples Survey 2024	Awaiting publication of report: May 2025
National Urgent and Emergency Care Survey 2024	Published November 2024

The full results for all the latest Care Quality Commission's national patient surveys can be found on their website at www.cqc.org.uk.

National Urgent and Emergency Care Survey

The 2024 survey asked people who attended A&E during February 2024 for feedback on their visit. Responses were received from 345 people at MWL.

The Trust performed the same as other organisations with 10 being the highest score:

Section	Score	Compared with other trusts
Arrival	7.1/10	About the same
Waiting	4.8/10	About the same
Privacy	7.2/10	About the same
Doctors and Nurses	7.2/10	About the same
Care and Treatment	6.7/10	About the same
Tests	7.7/10	About the same
Hospital Environments and facilities	6.3/10	About the same
Support recovery at home	7.0/10	About the same
Leaving A&E	7.1/10	About the same
Respect & Dignity	8.0/10	About the same
Experience overall	6.9/10	About the same

The Trust intends to take the following improvement actions following the results of the National Urgent and Emergency Care Survey.

- Improve waiting times for patients when they attend the emergency department by ensuring waiting times continue to be escalated and discussed at bed meetings throughout the day.
- Keep patients up to date with current wait times and ensuring they are kept updated of any changes throughout their time in the department through utilisation of screens.
- Displaying signs in the waiting room explaining how patients can alert staff if they are feeling more unwell or are in pain to ensure patients feel they can get help from members of staff with their conditions and symptoms whilst they are waiting.
- With the support of the pharmacy team, introduce a process to provide a standardised patient guidance sheet with new medications dispensed in the Emergency Department to ensure patients have the opportunity to ask any questions and have a contact number if they have further questions.
- Ensure patients will feel they have enough information to manage their condition at home by utilising the daily safety huddle to reinforce to all staff the requirement for them to ensure robust and detailed discharge discussions are being held. This allows patients to ask further questions and gives staff the opportunity to provide any relevant information leaflets and contact numbers.
- Ensure patients will feel that they have enough privacy when discussing their conditions with the department receptionist by displaying a poster at reception informing them that there is a private space available should they wish to request it.
- Ensure patients have the appropriate health and social care support in place if they are discharged from the ED, ensuring all staff complete the discharge checklist which will be monitored monthly via nursing care indicator audits.

National Maternity Survey 2024

The 2024 NHS Maternity Patient Experience Survey was undertaken between April and Aug 2023. 463 women aged 16 or over at the time of delivery who had given birth to a live baby between 1 January and 31 March 2024 at Whiston Hospital, Ormskirk Hospital or at home, were invited to give their views and feedback on the antenatal care, labour and birth, and postnatal care both in hospital and at home that they received.

170 people completed and returned the survey, which was a response rate of 37%. This was lower than the national average of 41%.

As this was the first survey undertaken as a combined trust there is no direct comparison to previous scoring and therefore the results provide a baseline for future comparison.

Of the 57 questions asked, MWL scored about the same as other Trusts in 48 questions, 5 questions somewhat worse and 4 questions worse than expected.

The results have been triangulated with other sources of patient feedback and a robust action plan has been developed to address the findings.

The table below details the overall section scores:

Section	Theme	Trust Score	Trust Ratings
Antenatal Care	Start of pregnancy	6.8	About the same
	Antenatal check-ups	7.8	Worse than expected
	During pregnancy	8.0	Worse than expected
	Triage assessment	8.7	About the same
Labour and Birth	Your labour and birth	8.0	About the same
	Staff caring for you	8.1	About the same
Postnatal Care	Care in the ward after birth	6.6	About the same
	Feeding your baby	7.8	About the same
	Care at home after birth	7.7	About the same
Complaints	Complaints	6.4	About the same

The questions which scored somewhat worse than expected were:

Question	Trust Score	National Average
B6. During your antenatal check-ups, did your midwives or doctors appear to be aware of your medical history?	6.1	7.0
B8. During your check-ups did your midwives listen to you?	8.6	9.1
B13. Thinking about your antenatal care, were you involved in decisions about your care?	8.4	8.9
B15. Did you have trust and confidence in the staff caring for you during antenatal care?	7.7	8.3
C16. Thinking about your labour and birth, were you involved in decisions about your care?	8.0	8.5

The questions which scored worse than expected were:

Question	Trust Score	National Average
B4. Did you get enough information from either a midwife or a doctor to help you decide where to have your baby?	5.5	6.8
B7. During your antenatal check-ups were you given enough time to ask questions or discuss your pregnancy?	8.1	8.9
B17. If you raised a concern during your antenatal care, did you think it was taken seriously?	7.7	8.8
B18. Thinking about your antenatal care, were you given information about any warning signs to look out for during your pregnancy?	7.7	8.6

The Trust intends to take the following actions to improve results from the National Maternity Survey:

- Procurement of reclining chairs on Whiston Hospital site to facilitate comfortable stay, and support partners or someone else close to the patient involved in their care being able to stay with them as much as the patient wants.
- Review of birth choices leaflet and Trust website to ensure patients get enough information from either a midwife or doctor to help decide where to deliver.
- Develop communication guidance to support midwives' and doctors' conversations to be used at the end of each patient contact to specifically ask the patient if there are any concerns / issues that remain unaddressed or require more clarity.
- Implement a new clinical system and full digitisation to enable easier and complete digital access to health records by all staff to ensure that during antenatal check-ups patients felt midwives or doctors appear to be aware of their medical history.
- Introduce antenatal education session which promotes use of BRAIN tool regarding shared decision making throughout pregnancy, birth and the postnatal period.

National General Practice (GP) Patient Survey

Marshalls Cross Medical Centre participates in the National GP Patient Survey each year. In 2024, 126 surveys were returned from a total of 419 resulting in a response rate of 30%.

Question	Marshalls Cross	National Results
-find it easy to get through to this GP practice by phone	35%	50%
-find it easy to contact this GP practice using their website	54%	48%
-find it easy to contact this GP practice using the NHS App	35%	45%
-find the reception and administrative team at this GP practice helpful	70%	83%
-usually get to see or speak to their preferred healthcare professional when they would like to	22%	40%
-were offered a choice of time or day when they last tried to make a general practice appointment	25%	53%
-were offered a choice of location when they last tried to make a general practice appointment	15%	13%
-felt they waited about the right amount of time for their last general practice appointment	53%	66%
-say the healthcare professional they saw or spoke to was good at listening to them during their last general practice appointment	80%	87%
-say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment	81%	85%

An improvement plan has been developed with GPs to address the identified areas of concern, and actions include:

- **Review Appointment Scheduling:** Implement a new scheduling system to improve appointment availability and reduce waiting times. Increase the number of same-day appointments available via additional overflow phone for appointments.
- **Improve Telephone Access:** The practice telephone system FINESSE (call waiting system) gives a comfort message, and queue number. The practice has 3 Patient Care Advisers (call handlers) to handle multiple queries, and appointments for booking on the day and advance bookings.
- **Staff Training:** Provide additional training for staff on effective communication skills and the importance of clear information sharing. Staff receive monthly training on patient engagement techniques.
- **Patient Information:** Revise and update patient information to ensure it is clear, comprehensive, and easy to understand. Staff will collate information in both digital and physical formats as requested.
- **Patient Involvement:** Multidisciplinary team approach to involve patients in their care decisions. GPs and other professionals gather patient input and preferences regarding their treatment plans and discuss their patient-centred care.
- **Monitoring and Feedback:** Establish a system for ongoing monitoring of patient satisfaction and the quality of care provided. Regular review of feedback, Friend and Family Test results are shared with GPs monthly and lessons learned are shared to ensure that issues are addressed promptly.
- **Reporting:** Provide quarterly updates on the progress of the action plan to ensure transparency and accountability. Share these updates with Patient Experience and stakeholders.

3.10 5-Star Accreditation Programme

NHS England recommends that locally driven ward/unit accreditation approaches bring together key measures into a single overarching framework. These programmes incorporate a set of standards so that areas for improvement can be identified as well as areas of excellence celebrated. These programmes can drive continuous improvement in outcomes, satisfaction and staff experience.

During this year we have created a new robust MWL accreditation programme. The programme utilises our existing audit tool, Tendable, which allows electronic data/results to be collected as well as photos and comments to be provided by the accreditation team.

Each of the 16 standards focuses on a key theme covering key quality elements of care: Documentation, Environmental Observations, Patient Questions / Experience, Staff Questions / Knowledge and Ward Manager Questions / Leadership.

An additional benefit of the programme is to help prepare the wards/clinical areas for a CQC visit. The process sets ambitious but realistic goals thereby taking wards/departments on a quality improvement journey. The accreditation framework has the following benefits:

- Targets setting consistent expectations of patient care delivery across the Trust
- Provides strong focus to the leadership team
- Strengthens leadership
- Improves quality
- Reduces avoidable harm
- Improves patient experience
- Provides evidence compliance against regulatory standards thus improving CQ ratings
- Improves clinical efficiency and effectiveness
- Shares good practice
- Team building

The ward/department accreditation framework provides Ward to Board assurance of quality and safety standards, highlighting performance across the five CQC key questions and the Trust's 5 star vision, celebrating success, and providing a platform for continuous improvement strategies.

Since launching the programme in June 2024, we have seen steady improvements across wards, as each accreditation is repeated (with the repeat timeframe dependent on final result). From first assessments to second assessments, it is clear to see the shift from Aspiring to 3,4 or 5 star awards.

Following assessments, clinical areas are provided with action trackers to develop and monitor their own improvement plans, and these are monitored within the divisions. We have also created an accreditation dashboard to identify areas of good practice and areas requiring improvement across all standards (also aligned to the CQC domains of safe, effective, caring, well-led and responsive). This provides assurance to board that results are being monitored and acted upon.

In January 2025 the Mersey Internal Audit Agency (MIAA) audited the MWL Accreditation Programme. From their report we received 'High Assurance' (the highest level possible) which shows:

'*There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed'.*

Appendix 1
National Clinical Audits

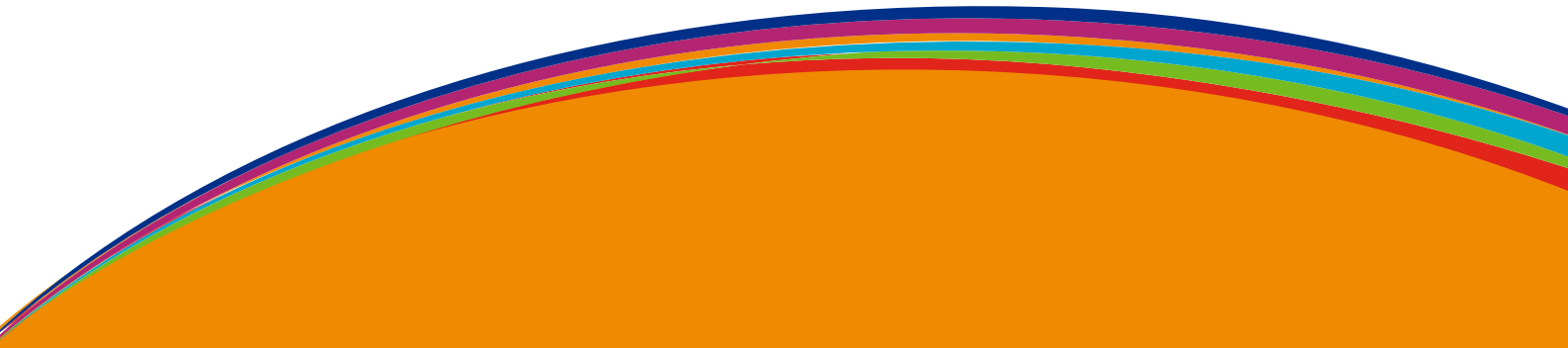
NHS England Quality Accounts List 2024-25. The table below lists the National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2024-25.

Number	Project Name	MWL Status
1	BAUS Penile Fracture Audit	Participating
2	BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Participating
3	BAUS Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Participating
4	Breast and Cosmetic Implant Registry	Participating
5	British Hernia Society Registry	Delayed national launch, aiming to participate
6	Case Mix Programme (CMP) - Intensive Care National Audit & Research Centre (ICNARC)	Participating
7	Child Health Clinical Outcome Review Programme	Participating
8	Cleft Registry and Audit NEtwork (CRANE) Database	Not applicable
9	RCEM - Adolescent Mental Health	Participating
10	RCEM - Care of Older People	Participating
11	RCEM - Time Critical Medications	Participating
12	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Participating
13	Fracture Liaison Service Database (FLS-DB	No service, not applicable
14	National Audit of Inpatient Falls (NAIF)	Participating
15	National Hip Fracture Database (NHFD)	Participating
16	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Participating
17	Maternal, Newborn and Infant Clinical Outcome Review Programme1	Participating
18	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Participating
19	Mental Health Clinical Outcome Review Programme	Not Applicable
20	National Diabetes Core Audit	Participating
21	Diabetes Prevention Programme (DPP) Audit	Not applicable
22	National Diabetes Footcare Audit (NDFA)	Participating
23	National Diabetes Inpatient Safety Audit (NDISA)	Participating
24	National Pregnancy in Diabetes Audit (NPID)	Participating
25	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Participating
26	Gestational Diabetes Audit	Participating
27	National Audit of Cardiac Rehabilitation	Participating
28	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	Not applicable
29	National Audit of Care at the End of Life (NACEL)	Participating

Number	Project Name	MWL Status
30	National Audit of Dementia (NAD)	Participating
31	National Bariatric Surgery Registry	Participating
32	National Audit of Metastatic Breast Cancer (NAoMe)	Participating
33	National Audit of Primary Breast Cancer (NAoPri)	Participating
34	National Bowel Cancer Audit (NBOCA)	Participating
35	National Kidney Cancer Audit (NKCA)	Participating
36	National Lung Cancer Audit (NLCA)	Participating
37	National Non-Hodgkin Lymphoma Audit (NNHLA)	Participating
38	National Oesophago-Gastric Cancer Audit (NOGCA)	Participating
39	National Ovarian Cancer Audit (NOCA)1	Participating
40	National Pancreatic Cancer Audit (NPaCA)	Participating
41	National Prostate Cancer Audit (NPCA)	Participating
42	National Cardiac Arrest Audit (NCAA)	Participating
43	National Adult Cardiac Surgery Audit (NACSA)	Not applicable
44	National Congenital Heart Disease Audit (NCHDA)	Not applicable
45	National Heart Failure Audit (NHFA)	Participating S&O sites behind with data collection
46	National Audit of Cardiac Rhythm Management (CRM)	Not applicable
47	Myocardial Ischaemia National Audit Project (MINAP)	Participating S&O sites behind with data collection
48	National Audit of Percutaneous Coronary Intervention (NAPCI)	Not applicable
49	National Audit of Mitral Valve Leaflet Repairs (MVLR)	Not applicable
50	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Not applicable
51	Left Atrial Appendage Occlusion (LAAO) Registry	Not applicable
52	Patent Foramen Ovale Closure (PFOC) Registry	Not applicable
53	Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Not applicable
54	National Child Mortality Database (NCMD)	Participating
55	National Clinical Audit of Psychosis (NCAP)	Not applicable
56	National Comparative Audit of NICE Quality Standard QS138	Participating
57	National Comparative Audit of Bedside Transfusion Practice	Participating
58	National Early Inflammatory Arthritis Audit (NEIAA)	Participating
59	National Emergency Laparotomy Audit (NELA)	Participating
60	National Joint Registry	Participating
61	National Major Trauma Registry [Note: Previously TARN. To commence data collection in 2024]	Participating
62	National Maternity and Perinatal Audit (NMPA)	Participating

Number	Project Name	MWL Status
63	National Neonatal Audit Programme (NNAP)	Participating
64	National Obesity Audit (NOA)	Participating
65	Age-related Macular Degeneration Audit - National Ophthalmology Database (NOD):	Participating
66	Cataract Audit - National Ophthalmology Database (NOD):	Participating
67	National Paediatric Diabetes Audit (NPDA)	Participating
68	National Perinatal Mortality Review Tool	Participating
69	National Pulmonary Hypertension Audit	Not Applicable
70	COPD Secondary Care	Participating
71	Pulmonary Rehabilitation	Participating
72	Adult Asthma Secondary Care	Participating
73	Children and Young People's Asthma Secondary Care	Participating
74	National Vascular Registry (NVR)	Participating
75	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Not applicable
76	Paediatric Intensive Care Audit Network (PICANet)	Not applicable
77	Perioperative Quality Improvement Programme	Not participating
78	Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour (POMH)	Not applicable
79	The use of melatonin (POMH)	Not applicable
80	The use of opioids in mental health services (POMH)	Not applicable
81	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology & Reconstruction	Not applicable
82	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	Not applicable
83	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	Not applicable
84	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma skin cancers	Participating
85	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	Participating
86	Sentinel Stroke National Audit Programme (SSNAP)	Participating
87	Serious Hazards of Transfusion (SHOT)	Participating
88	Society for Acute Medicine Benchmarking Audit (SAMBA)	Participating
89	UK Cystic Fibrosis Registry	Participating
90	UK Renal Registry Chronic Kidney Disease Audit	Not applicable
91	UK Renal Registry National Acute Kidney Injury Audit	Not applicable

Annex A
Statement of Directors' responsibilities in respect of the Quality Account



The Trust Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012) to prepare a Quality Account for each financial year.

The Department of Health issues guidance on the form and content of the annual Quality Account, which has been included in this Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered for 2024-25.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Trust Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Trust Board.

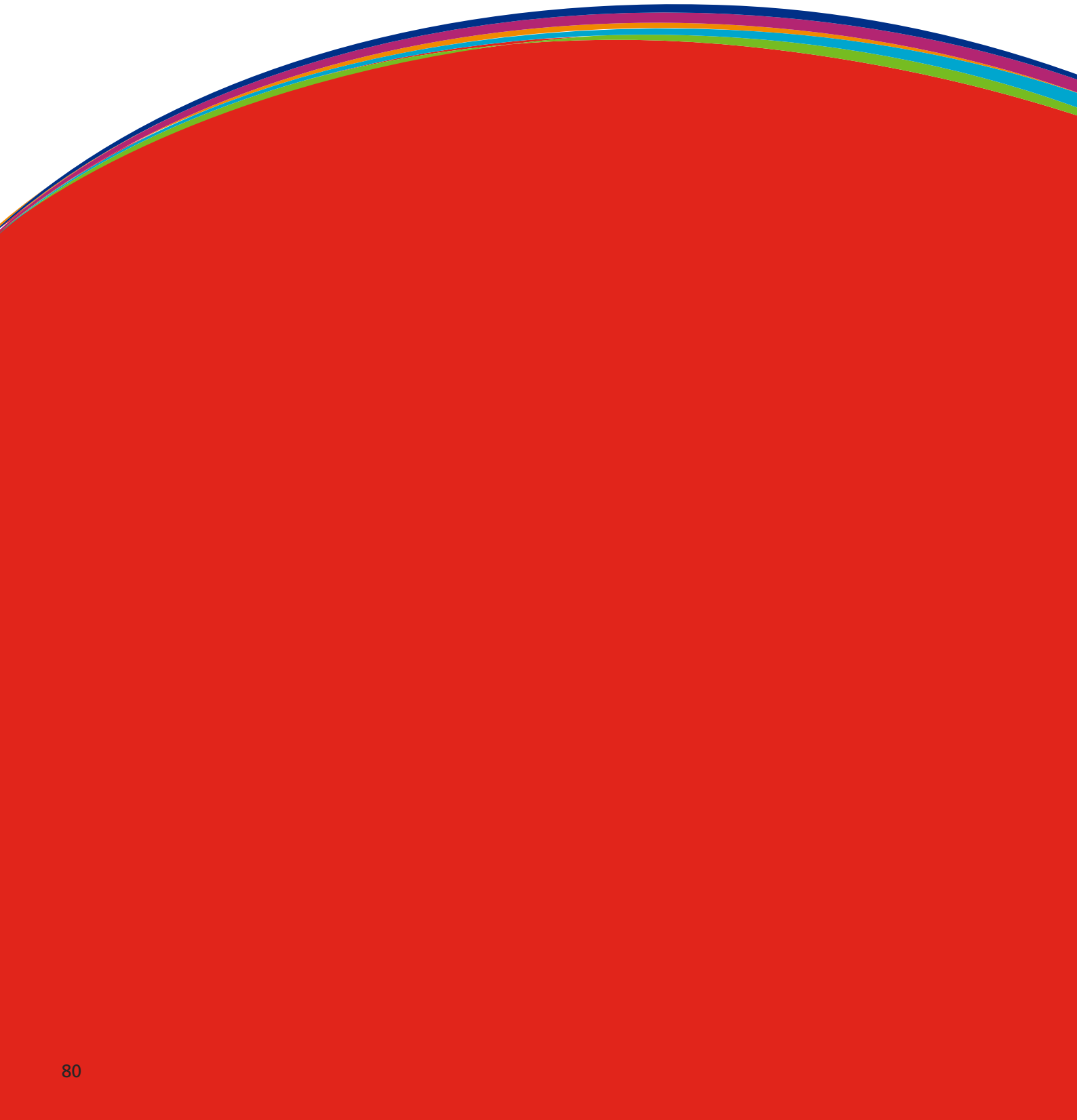
Steve Rumbelow

Steve Rumbelow, Chairman

Rob Cooper

Rob Cooper, Chief Executive

Annex B
Written statements by other bodies



Statement from NHS Cheshire and Merseyside ICB

NHS Cheshire and Merseyside has worked closely with Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) throughout 2024/25 and recognise the achievements made with regards to quality throughout the year. This is particularly noted against the backdrop of bringing two organisations together, providing sustainable high-quality services for the local population.

The achievements against the identified quality priorities have been built on significant work, fully achieving one priority around reducing harm associated to dehydration and notable success in all other priority areas. We will be working with MWL throughout 2025/26 to support completion of the remaining target areas specifically in relation to the challenges of patient flow demonstrated in the objectives for; all patients to be triaged or have baseline observations within 15 minutes of arrival and 20% of patients discharged before noon.

Similarly, it is positive that the Trust has continued the ambition to improve Infection Prevention and Control compliance standards as a priority for 2025/26 and the focus on improvement of patient experience is strongly supported with several patient experience metrics included within priority areas.

The Trust's active clinical audit programme has been described within the account and assures oversight of clinical effectiveness. The improvement journeys described around delirium, pleural effusion pathway, neonatal optimisation and smoking cessation are commendable. We will work closely with the Trust to understand more of the clinical audit findings requiring action during 2025/26 and support this delivery to allow further improvement journeys to be presented in the next quality account.

The Trust continues to demonstrate an open learning culture, particularly focusing on mortality related learning key lessons are shared transparently within the account. We will again work closely with the Trust to oversee the improvements made against these learning points.

Finally, it is recognised that the individual effort of staff and teams within the Trust make a huge impact to patient care. This is strongly recognised within the account through the highlighted awards and patient feedback. It is also positive to see the opportunities provided to volunteers to provide experience feedback and note the transition to substantive staff. This impact of individual staff is an important recognition from the Trust and acknowledgement of the great work that NHS staff can provide for patients.

Yours sincerely

Chris Douglas

Chris Douglas MBE (she/her)
Executive Director of Nursing & Care
NHS Cheshire and Merseyside ICB

cc. Kerry Lloyd, Lisa Ellis

Statement from Sefton Council's Overview and Scrutiny Committee

As Chair of Sefton Council's Overview and Scrutiny Committee (Adult Social Care and Health), I am writing to submit a commentary on your Quality Account for 2024/25.

On 26 May 2025 and along with the Committee Acting Vice-Chair, Cllr Dave Neary, I met with the Deputy Director of Governance Carol Fowler and the Director of Nursing and Midwifery, Lynne Barnes to consider your draft Quality Account.

We welcomed the opportunity to comment on your Quality Account and I have outlined the main comments raised in the paragraphs below.

We acknowledge and congratulate the hard work and success in many areas which has resulted in various improvements and awards, particularly those affecting our residents in Sefton, and pass on our thanks to all your staff and volunteers for their efforts.

Several issues were queried as follows:

- Reference was made to the layout of the Quality Account document and it was queried if it would be possible to provide an Executive Summary at the beginning of the document to make it easier to digest the information, particularly for the public.
- The addition of more graphs and pictures would help illustrate the information in some sections of the report.
- It was reassuring to note that the Trust had learnt lessons from the 'Never Events' and worked to ensure such events did not re-occur.
- The extent that corridors were being used to treat patients across the MWL area and how patient dignity and safety was being prioritised.
- The Trust's resilience in the event of a cyber-attack, especially at a point when more digitisation was being introduced.
- Congratulations were offered on the figures relating to cancer treatment targets.

As in the previous year, Ms Barnes indicated that she would be happy to facilitate another walkaround Southport Hospital for members of the Overview and Scrutiny committee.

Our Scrutiny Support Officer Laura Bootland, who also attended this meeting, will be in contact to arrange.

We appreciated the opportunity to scrutinise your draft Quality Account for 2025/26 and I hope you find these comments useful and recognise Scrutiny's role as the "critical friend" in this process.

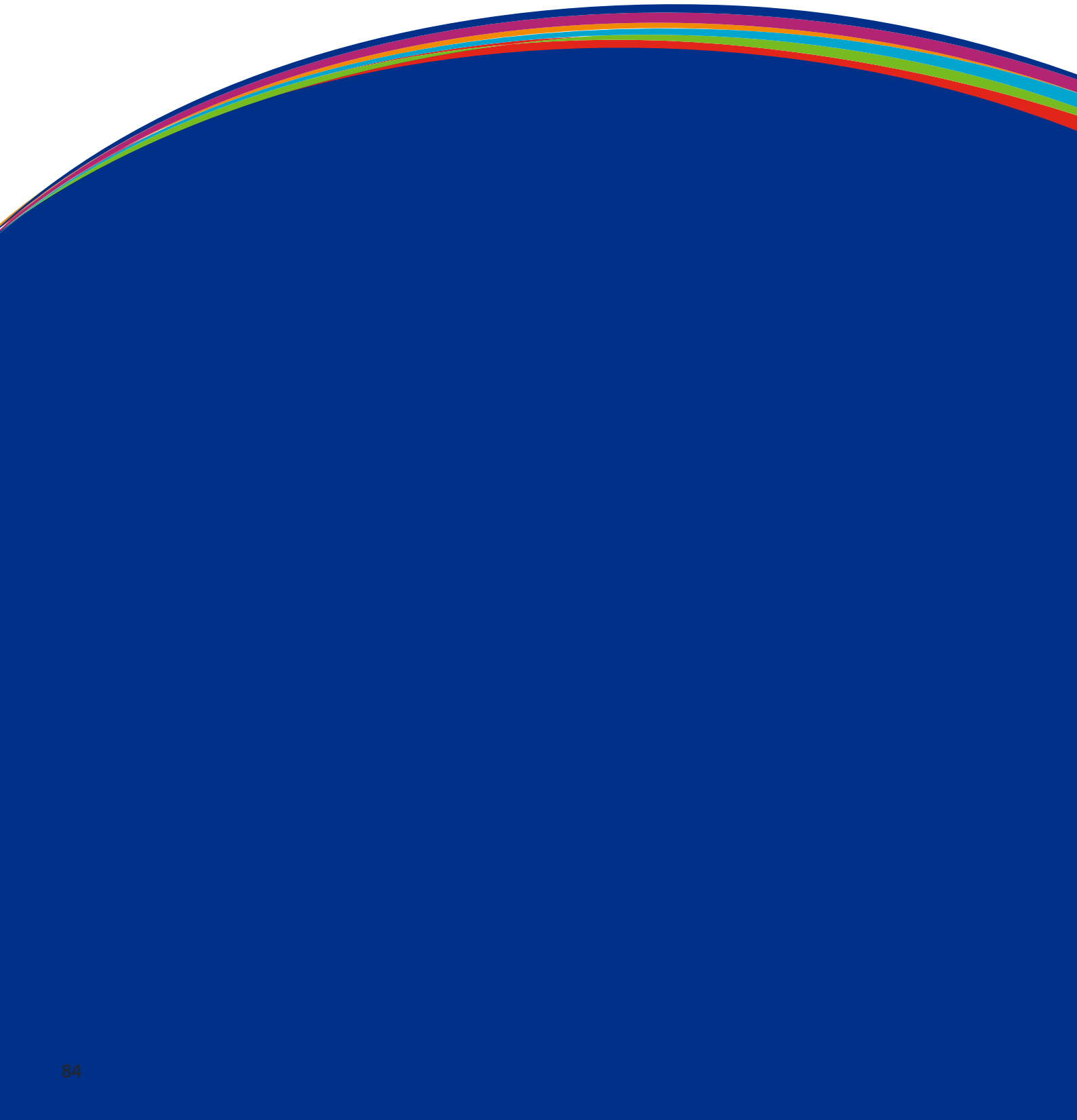
Please accept this letter as Sefton OSC's formal response to your Quality Account and I look forward to seeing the published Quality Account, together with our submission.

Statement from Healthwatch St Helens

Unfortunately, due to illness issues within the staff team, other commitments, and annual leave, we don't have the capacity this year to provide comment on the Quality Account.

Annex C

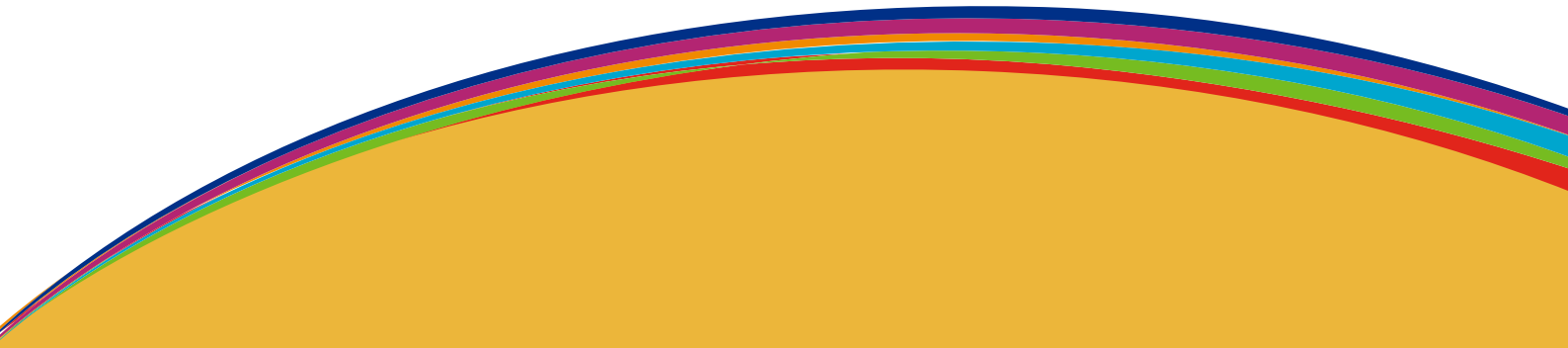
Amendments made to the Quality Account following feedback and written statements from other bodies



The following amendments were made following feedback from other bodies:

Section	Amendment/addition
2.2.7	Added section on ‘Cyber Security’.
3.6.4	Added update in relation to Sepsis under ‘Patient Safety’ section.
3.7	Included improvement actions for Marshalls Cross Medical Centre under ‘National General Practice (GP) Patient Survey’.

Annex D
Abbreviations



ADR	Adverse drug reaction
AHPs	Allied Health Professionals
AI	Artificial intelligence
AIS	Accessible Information Standard
AKI	Acute kidney injury
AMU	Acute Medical Unit
ANC	Ante-natal Clinic
ANTT	Aseptic non-touch technique
App	Application
AQ	Advancing Quality
AMaT	Audit Management and Tracking (computer package)
ARC NWC	Applied Research Collaboration North West Coast
BAME	Black, Asian and minority ethnic
BAUS	British Association of Urological Surgeons
BJP	Bence Jones Protein
BP	Blood pressure
BRAIN	Benefits, Risks, Alternatives, Intuition and Nothing – tool used during pregnancy to help parents get the information they need to make decisions about their care providers during pregnancy, birth and postpartum.
BSI	Blood stream infection
BSL	British Sign Language
BSPED	British Society for Paediatric Endocrinology and Diabetes
BTS	British Thoracic Society
CCS	Clinical Classifications Service
CD	Controlled drugs
C. difficile	Clostridioides difficile infection
CGM	Continuous glucose monitoring
CHPPD	Care hours per patient per day
CMAST	Cheshire and Merseyside Acute and Specialist Trust provider collaborative
CMP	Case mix programme
COO	Chief Operating Officer
COPD	Chronic obstructive airways disease
CPD	Continuing professional development
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQuIN	Commissioning for quality and innovation
CRAB	Copeland risk adjusted barometer
CRB	Cervical ripening balloon
CRN NWC	Clinical Research Network, North West Coast
CSP	Cervical Screening Programme
CT	Computerised tomography
CTG	Cardiotocography
CYP	Children and young people

Datix	Integrated risk management, incident reporting, complaints management system
DIEP	Deep inferior epigastric perforators
DIPC	Director of Infection Prevention and Control
DLQI	Dermatology Life Quality Index
DNA	Did not attend
DNACPR	Do not attempt cardiopulmonary resuscitation
DoN	Director of Nursing
DQMI	Data quality maturity index
DRC	Deafness Resource Centre
DrEaM	Drink, eat and mobilise
DSPT	Data Security and Protection Toolkit
DVT	Deep vein thrombosis
EASI	Eczema Area and Severity Index
ED	Emergency Department
EDI	Equality, diversity and inclusion
EDS or EDS2	Equality Delivery System
EMIS	Egton Medical Information System
ENT	Ear, nose and throat
ePMA	Electronic prescribing and medicines administration
EPR	Electronic patient record
ESR	Electronic staff record
eVTE	Electronic venous thromboembolism (recording)
FBC	Full blood count
FDA	Food and Drug Administration
FDS	Faster diagnosis standard
FFT	Friends & Family Test
FGR	Fetal Growth Restriction
FRAX	Fracture Risk Assessment Tool
FTSU	Freedom to speak up
GAP	Growth assessment protocol
GAP SCORE	Growth assessment protocol standardised case outcome review and evaluation
GI	Gastrointestinal
GIRFT	Get it right first time
GP	General Practitioner
HASU	Hyper-Acute Stroke Unit
HAT	Hospital-acquired or hospital-associated thrombosis
HbA1c	Haemoglobin A1c - average blood glucose (sugar) levels for the last two to three months
HCA	Healthcare Assistant
HCAI	Healthcare associated infections
HCSW	Healthcare Support Worker
HES	Hospital Episode Statistics
HHS	Hyperosmolar Hyperglycaemic State
HPMA	Healthcare People Management Association

HR	Human Resources
HS	Hidradenitis Suppuritiva
HWWB	Health, Work and Well-being
IBD	Inflammatory bowel disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
ICB	Integrated Care Board
ICCR	Individual care and communication record
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
ICS	Integrated Care System
IG	Information governance
IMCA	Independent mental capacity advocate
IPC	Infection prevention and control
IT	Information technology
IV	Intravenous
JAK	Janus Kinase
JSNA	Joint Strategic Needs Assessment
KPI	Key performance indicator
LAC	Looked after children
LeDeR	Learning disability mortality review
LFPSE	Learn from Patient Safety Events
LGA	Large for gestational age
LGBT	Lesbian, gay, bisexual, transgender
LGBTQIA+	Lesbian, gay, bisexual, transgender, questioning, intersex, asexual
LocSSIPs	Local safety standards for invasive procedures
MBRRACE-UK	Mothers and babies - reducing risk through audits and confidential enquiries across the UK
MDT	Multi-disciplinary team
MINAP	Myocardial infarction national audit programme
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant staphylococcus aureus
MRSAb	Methicillin-resistant staphylococcus aureus bacteraemia
MWL	Mersey and West Lancashire Teaching Hospitals NHS Trust
NACAP	National asthma and COPD audit programme
NACEL	National audit of care at the end of life
NAOGC	National audit oesophago-gastric cancer
NatSSIPs	National safety standards for invasive procedures
NBOCA	National bowel cancer audit
NCAA	National cardiac arrest audit
NCAP	National cardiac arrest programme
NCCQ	National clinical coding qualification
NCEPOD	National confidential enquiry into patient outcome and death
NCPES	National cancer patient experience survey
NDA	National diabetes audit

NELA	National emergency laparotomy audit
NEWS	National early warning score
NG	Nasogastric
NHS	National Health Service
NHSE	National Health Service England
NHSP	NHS Professionals
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National joint registry
NLCA	National lung cancer audit
NMPA	National maternity and perinatal audit
NMTR	National Major Trauma Registry (formerly TARN)
NNAP	National neonatal audit programme
NOD	National ophthalmology audit
NPCA	National prostate cancer audit
NPDA	National paediatric diabetes audit
NRLS	National Reporting & Learning System
NVR	National Vascular Registry
OBE	Order of the British Empire
ODPs	Operating Department Practitioners
OH	Occupational Health
OPCS	Office of Population, Census and Statistics Classification of Interventions and Procedures
OSCE	Objective structured clinical examination
OT	Occupational Therapist/Therapy
P2, P3, P4	Priority 2, 3, 4
PALS	Patient Advice and Liaison Service
PACS	Picture archiving and communication system
PAS	Patient administration system
PCC	Prothrombin complex concentrate
PCI	Percutaneous coronary intervention
PE	Pulmonary embolus
PIR	Post infection review
PLACE	Patient-led assessments of the care environment
PMRT	Perinatal mortality review tool
PRES	Participant in research experience survey
PROMs	Patient reported outcome measures
PSII	Patient safety incident investigation
PSIRF	Patient Safety Incident Response Framework
QI	Quality improvement
QICA	Quality Improvement and Clinical Audit
RAG	Red, amber, green
RCEM	Royal College of Emergency Medicine
RDI	Research, development and innovation

RDIG	Research, Development and Innovation Group
RCOG	Royal College of Obstetricians and Gynaecologists
RLC	Rugby League Cares
RN	Registered Nurse
RNDA	Registered Nurse Degree Apprenticeship
RTT	Recruiting to time and target
RSV	Respiratory syncytial virus
SAG	Safeguarding Assurance Group
SAMBA	Society for Acute Medicine (SAM) benchmarking audit
SAU	Surgical Assessment Unit
SBAR	Situation, background, assessment, recommendation
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SFLC	Serum free light chains
SHMI	Summary hospital-level mortality indicator
SHOT	Serious hazards of transfusion
SIRO	Senior Information Risk Owner
SJR	Structured judgement review
S&O	Southport and Ormskirk Hospital NHS Trust
SOP	Standard operating procedure
SSI	Surgical site infection
SSNAP	Sentinel stroke national audit programme
STHK	St Helens and Knowsley Teaching Hospitals NHS Trust
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TAR	Transfusion authorisation record
TAT	Thrombin-Antithrobin Complex
TIA	Transient ischaemic attack
TILIA	Tozorakimab in Patients Hospitalised for Viral Lung Infection Requiring Supplemental Oxygen
TNA	Trainee nursing associate
TTO	To take out
TURBT	Transurethral resection of bladder tumour
TURP	Transurethral resection of prostate
uDNACPR	Unified do not attempt cardiopulmonary resuscitation
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
UK	United Kingdom
VBAC	Vaginal birth after caesarean
VIP	Visual infusion phlebitis
VTE	Venous thromboembolism
WDES	Workforce Disability Equality Standard
WHO	World Health Organisation
WRES	Workforce Race Equality Standard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Contact details

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