Mersey and West Lancashire Teaching Hospitals NHS Trust

Equality Delivery System (EDS)

Annual Report

2026

Contents

1. Introduction

The Equality Delivery System (EDS) is an annual self-assessment exercise mandated by NHSE to review equality, diversity, inclusion and health inequalities activities across three domains, patient services, workforce health and wellbeing, and inclusive leadership practices. Each subsection, domain, and overall score is marked out of 4 – Undeveloped, Developing, Achieving and Excelling. For an excelling score to be achieved, activity or data needs to demonstrate that the majority of assessment areas are scoring are covering the majority of EDI/HI groups and/or achieving 70%+ positive response rates (staff survey).

This report provides the overall scores for each domain and sub-domain, summary evidence statements, and Appendix 1 provides the complete EDS 2026 Report as per the NHSE template.

1.1. Summary of Scores

Doman 1: Commissioned or provided services

Service: Diabetes and Endocrinology Teams	**Scores**
1A: Patients (service users) have required levels of access to the service	Achieving
1B: Individual patients (service users) health needs are met	Excelling
1C: When patients (service users) use the service, they are free from harm	Excelling
1D: Patients (service users) report positive experiences of the service	Excelling
Overall score	**Excelling**
Service: Radiology Services	**Scores**
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
Overall score	**Excelling**
Service: Interpreting Service	**Scores**
1A: Patients (service users) have required levels of access to the service	Achieving
1B: Individual patients (service users) health needs are met	Achieving
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
Overall score	**Achieving**
Domain 1 overall score	**Excelling**

Domain 2: Workforce health and well-being	Scores
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Achieving
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Achieving
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Achieving
2D: Staff recommend the organisation as a place to work and receive treatment	Achieving
Overall score	**Achieving**
Domain 3: Inclusive Leadership	**Scores**
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Achieving
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Achieving
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Achieving
Overall score	**Achieving**
EDS 2026 Overall score	**Achieving**

1.2. Summary of Evidence

1.2.1. Domain 1: commissioned or provided services

In 2025 we decided to do things a little differently and chose two provided services and one commissioned service instead of three provided services as we have done previously. These services were:

- Radiology (all sites)
- Diabetes (all sites)
- Interpreting services (al sites)

Prior to the assessments taking place patients and service users who had accessed each service were identified and if they had consented to, were ask to complete patient experience surveys asking them to rate their experience of the service they had used and how accessible to service and the information both verbal and written was for them. Paper copies of the surveys were sent out with a covering letter and a

SAE (so patients could return free of charge) and could also be completed online via a QR code on the survey covering letter.

To ensure that our surveys were accessible translated versions of the surveys and survey letters relating to the users of our interpreting service were provided in British Sign Language (BSL) and our most frequently requested foreign languages:

- Arabic
- Polish
- Romanian
- Portuguese
- Traditional Chinese
- BSL

Survey response rates were fair with the majority of respondents choosing to return the paper copy rather than complete the online version, which could be reflective of the high levels of digital exclusion in some of the areas the Trust serves.

Responses from each of the services are very positive:

Diabetes and endocrinology

- 100% of respondents felt they could access the service when needed,
- 93% felt their needs were met,
- 100% rated the overall service as positive,

Friends and family test (FFT) results show that 98.89% of patients would recommend the service.

Radiology

- 99% of respondents felt they could access the service when needed,
- 98% rated the overall service as positive,

Friends and family test (FFT) results show that 92.4% of patients would recommend the service.

Interpreting services

- 93% of respondents felt they could access the service when they needed to,
- 98% rated the overall service as positive.

1.2.2. Domain 2: Workforce health and well-being Summary

The Trust demonstrates a comprehensive and proactive approach to staff wellbeing, safety, inclusion, and experience, supported by structured policies, data-driven processes, and a wide range of support mechanisms.

A dedicated **Health Work and Wellbeing** (HWWB) team monitors workforce health, undertakes pre-employment checks, delivers occupational health services and provides targeted psychological, physical and disability-related support. Staff benefit from extensive self-help resources, mental health professionals, the Employee Assistance Programme and a Wellbeing Hub that offers regular events, campaigns and eLearning opportunities. Absence and sickness data are closely monitored, with wellbeing meetings, reasonable adjustments, stress risk assessments and structured return-to-work plans used to support retention. User data informs service development, although EDI-segmented analysis is not yet consistently applied. The exit interview process has recently been strengthened to capture better workforce insights.

The Trust operates a firm **zero-tolerance** approach to **verbal and physical abuse**. This is reinforced by more than fifteen policies and supported through regular communication from leadership. Visibility and prevention are enhanced through posters, intranet hubs and the deployment of body cameras in key areas. Staff receive training in bullying, harassment, sexual safety, domestic abuse, conflict resolution, lone working and violence reduction. A partnership with Merseyside Police through **Operation Cavell** enables effective reporting and prosecution of abusive behaviour, including hate crime and violence. Clear pathways exist for staff—particularly those with protected characteristics—to raise concerns through line managers, HR, Freedom to Speak Up, EDI, trade unions and security teams.

Bullying and harassment are treated as gross misconduct under the Trust's disciplinary framework and Respect & Dignity policy. The Trust strengthens prevention through Cultural Competency training, Active Bystander training, management development and wider equality awareness. **Freedom to Speak Up** is firmly embedded, with four Guardians and more than forty Champions providing confidential routes for raising concerns. **Staff networks and pledges**, including Anti-Racism, Sexual Safety and LGBT Inclusion pledges, help promote inclusive behaviours and contribute to tackling concerns. Although networks receive funding and support from the EDI Team, the lack of chairs in several networks limits their autonomy.

The Trust undertakes extensive **analysis of staff survey results** across all protected characteristics, including disability, ethnicity, gender, sexual orientation, age and religion, as well as at intersectional levels. These insights inform EDI priorities, operational planning and department-level actions. Harassment, violence, safeguarding and security data are routinely reviewed through WRES, WDES and EDS frameworks. Staff Survey results highlight variations in harassment rates across EDI groups, prompting targeted improvements, such as the introduction of Active Bystander training.

The Trust **works with a wide range of partners—**including NHS regional bodies, local authorities, voluntary groups, charities, EAP providers, Armed Forces networks and national standards frameworks—to strengthen staff support and align with the NHS People Plan. It also contributes to broader system initiatives such as the Rainbow Charter and regional Anti-Racism programmes.

Although the staff survey does not measure whether local staff use Trust services, between 50 and 69.9 percent of staff say they would recommend the Trust as both a place to work and a provider of patient care. Staff also score the Trust above the NHS average for patient-centredness and responsiveness, reflecting strong organisational confidence and reputation.

1.2.3. Domain 3: Inclusive leadership Summary

Board members, system leaders and senior managers ensure **strong oversight, governance and performance** management of equality, diversity, inclusion (EDI) and health inequality commitments. Through a comprehensive governance structure—including the Board, Strategic People Committee, People Performance Council, Valuing Our People Council and the Patient Experience Council—leaders review, monitor and challenge progress across all statutory and strategic EDI tools.

The Trust implements and monitors all major **EDI and health inequalities frameworks**, including WRES, WDES, EDS, PCREF, the NHS Oversight Framework, gender pay gap reporting, accessible information standards, EIAs, staff risk assessments and exit interviews. These reports are routinely presented to the Board or subcommittees, with action plans approved and monitored to ensure required improvements are delivered.

Where **gaps or unmet objectives** are identified, interventions are incorporated into the HR People Plan, Patient Experience & Inclusion Strategy, staff survey action plans and relevant operational plans. These annual plans embed EDI as a cross-cutting enabler and set out measurable commitments reviewed during the year.

Senior leaders demonstrate active commitment to **supporting staff needs**, including through a well-established Menopause Policy and a Menopause Network with over 350 members. Events, peer support and wellbeing advice are supported by the Health, Work & Wellbeing team.

The Trust maintains strong **partnership working** with system organisations including the Cheshire & Merseyside ICB, NHS England/North West EDI teams, local Trusts, Healthwatch and trade unions. These partners participate in committees such as the Equality Steering Group and contribute to patient and staff voice activities.

Workforce composition is monitored for senior bands. Band 8C+ and Band 7+ show higher representation of women, BAME staff and several religious groups compared to the local population, but significantly lower representation of disabled staff, younger staff (especially 16–24), and men (Band 7+).

The Trust shows year-on-year improvement across multiple **equality indicators**. WRES demonstrates an improvement trend in 7 of 13 indicators over two years (and 5 of 13 over three years). WDES shows improvement in 6 of 15 indicators over two years (and 6 over three years). Gender pay gap reporting demonstrates positive trends with multi-year reductions in mean and median pay gaps and improved bonus metrics.

Board members and committees actively **monitor the impact** of all improvement actions. Standing agenda items include WRES, WDES, pay gaps, Sexual Safety Charter, patient inclusion, FTSU, safeguarding and violence reduction. EDI action plans are monitored through PPC, VOPC, Strategic People Council and the Patient Experience Council, ensuring accountability across workforce and patient services.

Overall, Board members and senior leaders ensure that robust levers, systems and monitoring processes are in place to deliver, track and improve equality and health inequality outcomes for staff and patients.

1.2.4. Action Plan Summary

A short action plan is included at the end of the report, (see 2.6 EDS Action Plan) with the majority of actions being delivered via the Trust People Plan, Patient Experience & Inclusion Strategy and associated action plans. The overarching objectives are:

Domain 1

- Consistent information provided to patients across sites.
- Easy read information being accessible to patients.
- Increase patient feedback (S&O sites)
- Increase the number of interpreters and languages spoken to improve patients access to the service
- Increase the access to video interpreting across the Trust including iPads that are dedicated to this purpose and speakers that can be used on desktops in clinic area
- Ensure staff have the necessary skills to work with interpreters and know when an interpreter is essential throughout the patient journey
- Identify any gaps in methods of communication that may disadvantage patients with additional communication needs
- Increase patient feedback

Domain 2

- Improve Health Inequalities data capture and analysis for staff
- Reduce incidents of bullying and harassment
- Ensure up to date information is available to staff, and sign posting
- To increase staff satisfaction with EDI practices

Domain 3

- To increase all staff members EDI competence
- To ensure and equip senior leaders to understand the equality impact assessment process
- To ensure that EDI data is readily available and accessible when needed
- Improve EDI Governance and Staff Network structures

2. Appendix 1: NHS Equality Delivery System (EDS) Report 2026

Name of Organisation	Mersey & West Lancashire Teaching Hospital NHS Trust (MWL)
Name of Integrated Care System	Cheshire and Merseyside ICB
Organisation Board Sponsor / Lead	• **Malise Szpakowska,** Chief People Officer • **Sarah O'Brien** Chief Nursing Officer
EDS Lead	• **Cheryl Farmer** Head of Patient Equality, Diversity, Inclusion and Experience • **Darren Mooney** Head of Equality, Diversity & Inclusion (Workforce)
At what level has this been completed?	NHS Trust / Organisation Level
EDS engagement date(s)	January – April 2026
Individual organisation:	N/A
Partnership* (two or more organisations):	Healthwatch (Sefton, St Helens, Knowsley, Halton, West Lancs)
Integrated Care System-wide:	Cheshire and Merseyside ICB
Date completed	04/2026
Date authorised	04/2026
Revision date	02/2027
Month and year published	03/2026

2.1. Completed actions from previous year

Action/activity	Related equality objectives
Implement new OH/HWWB management system	2A, 2B, 2C
Implement Socio-Economic question in ESR	2A
Launch new training on Harassment & Civility, Cultural Competence, Active Bystander.	2B, 2C,
Introduce Sexual Misconduct Policy	2B, 2C
Continue to develop HWWB/OH web resources	2B, 2C, 2D
Review EDI Hubs	2B, 2C, 2D
Create a Sexual Harassment Hub	2B, 2C, 2D
Implement a EDI training objective for all staff in the appraisal	2D, 3A
Roll out new exit interview processes and review for common themes and take action	2D, 3C
Introduce new training resources on sexuality, trans and race equality	2D, 3B
Chief Executive to be appointed Senior Race Equality Champion	3A, 3B, 3C

2.2. EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below	
Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

2.3. Domain 1: Commissioned or provider services

2.3.1. Diabetes and Endocrinology Services

Outcome	Evidence	Rating	Owner (Dept/Lead)
1A: Patients (service users) have required levels of access to the service	**Whiston and St Helens sites submission** The service offers: • Assessment, diagnosis and management of diabetes related conditions with access to investigations as needed, typically through consultant led diabetes new patient clinic. • A number of subspeciality diabetes related clinics including: • Diabetes antenatal clinic – including pre-planning and gestational diabetes clinics • Diabetes foot clinic • Diabetes technology clinic – including access to insulin pump therapy and Continuous Glucose Monitoring (CGM) equipment • Diabetes specialist dietitian clinics • Diabetes glucose balance clinics • Diabetes young adults clinics • Diabetes nephropathy clinics • Diabetes telephone support clinics • Diabetes insulin safe start clinics • Diabetes technology virtual telephone clinics • Diabetes education clinics • Diabetes insulin safe adjustment clinic • Diabetes carb refresher clinic • Diabetes Insulin Carbohydrate Education clinic (ICE) • Diabetes emergency access/quick access slots (to enable urgent reviews & access to clinic within the week) The department also has access to weekly specialist multidisciplinary team meetings with orthopaedic, microbiologists and vascular team members to advise on the management of complex foot patients. Group education or 1-1 sessions are also delivered to support newly diagnosed diabetes patients, with 1-1 flexible education sessions which can be adapted for patients with additional needs.	2	Diabetes Centre St Helens Diabetes Service Southport and Ormskirk

Outcome	Evidence	Rating	Owner (Dept/Lead)
	If required, the department signposts to support services such as community based, third sector providers in relation to healthy eating, weight management services, bariatric services, smoking, drug and alcohol management services, local diabetes support groups, wellbeing services, online educational support resources and psychology support. The diabetes inpatient services provide a review and support for patients who are admitted with a primary diabetes related condition or whose condition requires support and advice regarding management during their inpatient stay. This may include diagnosing diabetes, supporting Diabetic Ketoacidosis (DKA) management, severe hypoglycaemia management or a general diabetes medication review. The inpatient team operate a seven-day service, 365 days a year so that patients can be reviewed timely and prevent delays in care if admitted over a weekend or holiday period. The diabetes inpatient service has achieved Diabetes Care Accreditation Programme (DCAP) accreditation level 1 for its inpatient work and is currently working towards level 2 accreditation. The diabetes outreach services support GP practices (joint review clinics with practice nurses), local care and nursing homes, frailty ward rounds, YMCA, Change Grow Live (CGL) service which supports individuals with drug or alcohol recovery, Hope House (homeless drop-in centre) and similar associations with diabetes advice and management plans. These services are examples of the outreach diabetes team supporting vulnerable adults within the wider community who may not have the ability to travel to attend routine appointments or due to personal reasons or other circumstances may need additional support in managing their diabetes. In 2023/4 we saw 91 clients (YMCA, CGL, Hope House), including 9 people we diagnosed with pre-diabetes (30% of whom achieved remission), 1 with newly diagnosed type 2 diabetes, 4 of 6 who received education and care, 1 newly diagnosed type 1 diabetic who was stabilised and started on treatment without the need for hospital admission and 12 people with established diabetes, including one person who optimised his blood sugars after 6 visits and one we helped secure an insulin pump. A number of evening, virtual and telephone clinics/appointments are available within the service to support patients who find it difficult to attend routinely throughout the day or for example, elderly or disabled patients who need a relative to bring them or support them with appointments.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Patients are referred into the outpatient diabetes service via a health care professional such as their GP using the Electronic Referral System (ERS), or via the inpatient diabetes team when a patient has been admitted or needs further review post an inpatient stay in hospital. Referrals are triaged by senior members of the diabetes team and allocated a clinic appointment in the appropriate service such as a new patient clinic for assessment with a consultant or dietitian clinic for an assessment with a dietitian. The diabetes team also offers an online advice and guidance service to support GP's with appropriate advice and support, this can be done via ERS, the diabetes specialist outreach team email. diabetesspecialistoutreachteam@merseywestlancs.nhs.uk, or by telephone to a dedicated outreach support telephone line,(01744 646200 option 3). Information about the diabetes service and St Helens diabetes team can be found on the internet for patients to access. The team can be contacted via telephone with a diabetes Emergency Advice Line (EAL) out of hours service (01744 646200 option 5) for emergency advice available to patients, carers and health care professionals. There is the ability to leave non-urgent routine messages which will be returned by a member of the diabetes team within 3 days (01744 646200 option 2). The young adults team, diabetes specialist outreach team and diabetes inpatient team can also be contacted via email: • diabetesspecialistoutreachteam@merseywestlancs.nhs.uk, • young.adultdiabetes@merseywestlancs.nhs.uk, • diabetesinpatientnurses@merseywestlancs.nhs.uk. Appointments are sent out via letter; the team also use an appointment reminder text messaging service to inform patients of their appointments. Patients are able to cancel or reschedule appointments via telephone with the diabetes reception team, or via the appointments team. The team also use an appointment reminder text messaging service, as well as the ability to cancel or reschedule appointments online for patients who are unable to access the telephone. • STHK Ev01 – Your appointment webpage (Mersey and West Lancashire Teaching Hospitals NHS Trust STHK | How to change or cancel your appointment) Information regarding the St Helens diabetes team can be found on the MWL internet pages with information regarding staff and services provided		

<table>
<tr><th>Outcome</th><th>Evidence</th><th>Rating</th><th>Owner (Dept/Lead)</th></tr>
<tr><td></td><td>
STHK Ev02 – Diabetes webpage (Mersey and West Lancashire Teaching Hospitals NHS Trust STHK | Our Services)
Between 1st January 2025 – 31st December 2025, 3,546 individual patients were seen within the service. The overall figures are included in the patient demographic evidence with the charts for age, sex and ethnicity also included below.
STHK Ev03 – STHK patient demographics
Age
<table>
<tr><td>16-25 years</td><td>255</td><td>7.2%</td></tr>
<tr><td>25-34 years</td><td>719</td><td>20.3%</td></tr>
<tr><td>35-44 years</td><td>551</td><td>15.5%</td></tr>
<tr><td>45-54 years</td><td>383</td><td>10.8%</td></tr>
<tr><td>55-64 years</td><td>625</td><td>17.6%</td></tr>
<tr><td>65-74 years</td><td>579</td><td>16.3%</td></tr>
<tr><td>75-84 years</td><td>325</td><td>9.2%</td></tr>
<tr><td>85-94 years</td><td>104</td><td>2.9%</td></tr>
<tr><td>95-104 years</td><td>5</td><td>0.1%</td></tr>
</table>
Sex
<table>
<tr><td>Female</td><td>1943</td><td>54.8%</td></tr>
<tr><td>Male</td><td>1601</td><td>45.1%</td></tr>
<tr><td>Not Specified</td><td>2</td><td>0.1%</td></tr>
</table>
Ethnicity
<table>
<tr><td>White British</td><td>3142</td><td>88.6%</td></tr>
<tr><td>White Irish</td><td>26</td><td>0.7%</td></tr>
<tr><td>Any other White background</td><td>88</td><td>2.5%</td></tr>
<tr><td>Mixed White and Black Caribbean</td><td>7</td><td>0.2%</td></tr>
<tr><td>Mixed White and Black</td><td>4</td><td>0.1%</td></tr>
<tr><td>Mixed White and Asian</td><td>11</td><td>0.3%</td></tr>
<tr><td>Mixed Other</td><td>16</td><td>0.5%</td></tr>
<tr><td>Indian (Asian/Asian British)</td><td>24</td><td>0.7%</td></tr>
</table>
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</table>

Outcome	Evidence	Rating	Owner (Dept/Lead)

Pakistani (Asian/Asian British)	2	0.1%
Bangladeshi (Asian/Asian British)	2	0.1%
Asian other	45	1.3%
Caribbean (Black/Black British)	2	0.1%
African (Black/Black British)	18	0.5%
Black Other	9	0.3%
Chinese	10	0.3%
Any Other Ethnic Group	31	0.9%
Not Stated	109	3.1%

As part of EDS22, patients who visited the service were sent a survey with a combination of questions, designed to evidence how patients can access the service, their needs are met, they are free from harm and were allowed to share positive feedback. Throughout the year, 187 surveys were sent to patients with 21 responses being received which equates to an 11% response rate.

- STHK Ev04 – STHK EDS22 survey results

Southport and Ormskirk submission

The Diabetes Team at Southport and Ormskirk legacy sites, provides diabetes outpatient services that cover the geographical area of North Sefton and West Lancashire.

The diabetes insulin pump services will be the focus of this review as the general diabetes outpatient service is currently consultant led only and does not include a nursing presence.

The diabetes insulin pump services are separated into two different teams/services – Young Persons (YP) services and adult pump services. The YP service specifically deals with patients between the ages of 18-25 years old, most of whom have transitioned from the paediatric diabetes service, although individuals who are diagnosed with diabetes within this age range will also fall within this service. Adult services care for those patients who are aged 25 and above.

Insulin pump therapy or Continuous Subcutaneous Insulin Infusion (CSII) is a mode of delivering intensive insulin therapy, which usually leads to improved glucose control and reduced hypoglycaemia (DTN-UK, 2018). NICE guidance (2008) recommends that CSII is used as a treatment option for adults and children 12 years and older with type 1 diabetes mellitus provided they meet certain criteria.

<table>
<tr><th>Outcome</th><th>Evidence</th><th>Rating</th><th>Owner (Dept/Lead)</th></tr>
<tr><td></td><td>
The YP service includes a diabetes consultant, diabetes specialist nurse (1WTE) and diabetes specialist dietitian.

The adult pump service includes a diabetes consultant and diabetes specialist nurse.

Patients can be referred into the service via their GP, community diabetes services or other specialist services, such as dietitians, podiatrists and surgeons if glucose control needs to be improved prior to a procedure.

For the YP service, the majority of the patients transfer from the paediatric diabetes team. They have two transition appointments when they are 16-17 years old so they can meet their new consultant and become accustomed to the new team. Patients who are between the ages of 18-25 years who are diagnosed with diabetes are often referred to the YP service following an emergency presentation.

For the adult pump service patients are usually referred in by a diabetes specialist (consultant or specialist nurse). For adult pump patients they are required to attend a general diabetes outpatient appointment first, to check their suitability for CSII therapy and complete some carbohydrate counting training. Once completed they will be transferred to the adult pump team for ongoing care.

Between 1st January 2025 – 31st December 2025, 234 individual patients were seen with the young persons and adult pump service. The overall figures are included in the patient demographic evidence with the charts for age, sex and ethnicity also included below.

• SO Ev01 – S&O patient demographics

Age

<table>
<tr><td>16-25 years</td><td>160</td><td>68.4%</td></tr>
<tr><td>25-34 years</td><td>14</td><td>6.0%</td></tr>
<tr><td>35-44 years</td><td>11</td><td>4.7%</td></tr>
<tr><td>45-54 years</td><td>14</td><td>6.0%</td></tr>
<tr><td>55-64 years</td><td>19</td><td>8.1%</td></tr>
<tr><td>65-74 years</td><td>13</td><td>5.6%</td></tr>
<tr><td>75-84 years</td><td>3</td><td>1.3%</td></tr>
</table>

Sex
</td><td></td><td></td></tr>
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<table>
<tr><th>Outcome</th><th>Evidence</th><th>Rating</th><th>Owner (Dept/Lead)</th></tr>
<tr><td></td><td>
<table>
<tr><td>Female</td><td>129</td><td>55.1%</td></tr>
<tr><td>Male</td><td>105</td><td>44.9%</td></tr>
</table>

Ethnicity

<table>
<tr><td>White British</td><td>207</td><td>88.5%</td></tr>
<tr><td>White Irish</td><td>1</td><td>0.4%</td></tr>
<tr><td>Any other White background</td><td>3</td><td>1.3%</td></tr>
<tr><td>Mixed White and Black Caribbean</td><td>0</td><td>0.0%</td></tr>
<tr><td>Mixed White and Black</td><td>0</td><td>0.0%</td></tr>
<tr><td>Mixed White and Asian</td><td>0</td><td>0.0%</td></tr>
<tr><td>Mixed Other</td><td>0</td><td>0.0%</td></tr>
<tr><td>Indian (Asian/Asian British)</td><td>0</td><td>0.0%</td></tr>
<tr><td>Pakistani (Asian/Asian British)</td><td>0</td><td>0.0%</td></tr>
<tr><td>Bangladeshi (Asian/Asian British)</td><td>0</td><td>0.0%</td></tr>
<tr><td>Asian other</td><td>1</td><td>0.4%</td></tr>
<tr><td>Caribbean (Black/Black British)</td><td>0</td><td>0.0%</td></tr>
<tr><td>African (Black/Black British)</td><td>0</td><td>0.0%</td></tr>
<tr><td>Black Other</td><td>3</td><td>1.3%</td></tr>
<tr><td>Chinese</td><td>0</td><td>0.0%</td></tr>
<tr><td>Any Other Ethnic Group</td><td>3</td><td>1.3%</td></tr>
<tr><td>Not Stated</td><td>16</td><td>6.8%</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>1B: Individual patients (service users) health needs are met</td><td>Whiston and St Helens site submission

For patients that require an interpreter we offer face to face, telephone and video depending on the type of interpreter required. Interpreters are booked for all relevant appointments to ensure patients are fully informed and that their health needs are met. Face to face is used for foreign language patients as well as deaf/blind patients, for foreign language patients telephone interpreters are also utilised and face to face or video is used for BSL and lip-reading patients. There is accessible information posters displayed in our waiting/reception areas to highlight to patients and carers to let reception or clinical staff know of any additional needs so that appropriate arrangements can be made when necessary.</td><td>3</td><td>Diabetes Centre St Helens

Diabetes Service Southport and Ormskirk</td></tr>
</table>

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• STHK Ev05 – AIS poster The St Helens diabetes service follows Trust policy and utilises the patient communication boxes on the diabetes unit (boxes contain communication aids for patients such as communication cards, magnifiers, personal listening devices, interpreter information). • STHK Ev06 – Policy to meet the communication needs of patients (including interpretation, translation and accessible information standard) The St Helens diabetes service ensures they provide adjustments for any patients with an electronic alert (patients who require additional communication support due to their disability or impairment) placed on their patient record. In addition to interpreters, we can translate patient information (such as appointment letters and patient information leaflets) for foreign languages or BSL via QR code linked to a signed video. We can also provide patient information in large print, easy read, CD and braille where requested. • STHK Ev06 – Policy to meet the communication needs of patients (including interpretation, translation and accessible information standard) Once a reasonable adjustment has been identified through a patient assessment, we aim to address these to aid the patient's journey. The team ensure to follow all Trust policies and procedures relating to patients with a learning disability and/or autism, as well as policies relating to patients' communication needs, carer support etc. The diabetes unit has a dedicated buzzer system which allows patients who need a quiet space to wait in an appropriate area rather than a busy wating area and be called back when the clinician is available for their appointment. An example of this can be using the system for patients with learning difficulties or autism who need a quiet or safe area to prevent any additional distress prior to their appointment. Patients with learning disabilities or additional needs such as those with an interpreter present, can also be offered a longer appointment to ensure that additional time can be taken to meet their needs and the information provided/discussed is understood. • STHK Ev06 – Policy to meet the communication needs of patients (including interpretation, translation and accessible information standard) • STHK Ev07 – Policy for the care of people with a learning disability and/or autism • STHK Ev08 – Implementation of orange wristband to identify reasonable adjustments for patients with a learning disability or autism • STHK Ev09 – Health passport		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	At the initial outpatient appointment, we provide contact details and information relating to the St Helens diabetes service. We have information leaflets to explain hospital stay and discharge for diabetes inpatients. We have many leaflets and support tools that we can provide to patients regarding their diabetes treatment and care. • STHK Ev10 – Diabetes ward discharge leaflet • STHK Ev11 – Diabetes ward discharge basal bolus leaflet • STHK Ev12 – Diabetes useful stuff about diabetes information booklet • STHK Ev13 – Diabetes ward discharge mixed insulin leaflet • STHK Ev14 – Diabetes type 2 & illness leaflet • STHK Ev15 – Diabetes Young Adults Clinic (YAC) leaflet • STHK Ev16 – Diabetes foot clinic leaflet • STHK Ev17 – Diabetes type 2 live well education programme leaflet • STHK Ev18 – Diabetes Insulin Carbohydrate Education (ICE) leaflet • STHK Ev19 – Diabetes advanced bolus options for insulin pumps leaflet • STHK Ev20 – Diabetes Charcot foot neuroarthropathy leaflet • STHK Ev21 – Diabetes and your eyes leaflet • STHK Ev22 – Diabetes snack list leaflet • STHK Ev23 – Dietary management of reactive hypoglycaemia leaflet • STHK Ev24 – Dietary management of gastroparesis leaflet • STHK Ev25 – Diabetes footwear advice leaflet STHK Ev26 – Diabetes foot clinic stretches leaflet • STHK Ev27 – Diabetes insulin pump training information leaflet • STHK Ev28 – Setting up your Dexcom One+ leaflet • STHK Ev29 – Setting up your Freestyle Libre 2 leaflet • STHK Ev30 – Dietary advice for wound healing • STHK Ev31 – Looking after your diabetic foot ulcer • STHK Ev32 – Diabetes Drug Information leaflet • STHK Ev33 – Diabetes and your eyes • STHK Ev34 – Diabetes kidney disease leaflet Newly diagnosed diabetes patients are offered structured education (type 2 live well) which can be face-to-face group education sessions. 1-1 individual sessions can also be arranged for patients who need reasonable adjustments or directed to appropriate online programmes such as NHS healthy living for type 2 diabetes. There is also an Insulin Carbohydrate Education (ICE) course for patients with type 1 diabetes which can be delivered in a small group session or a 1-1 individual session dependent upon patient need.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• STHK Ev17 – Diabetes type 2 live well education programme leaflet • STHK Ev18 – Diabetes Insulin Carbohydrate Education (ICE) leaflet • STHK Ev89 – Healthy living for people with type 2 diabetes Appointments can also be requested and adapted to suit the religious or cultural requirements of the service user, such as making an early or late appointment around religious festivals. Service users are available to request a chaperone to attend their appointment, as well as a male or female member of staff only in order to meet any cultural elements where safe and appropriate to do so as per Trust policy. • STHK Ev35 – Chaperone policy In addition, patients can be signposted to their local diabetes support groups for additional support during their clinical consultation. The St Helens diabetes unit reception area also displays information posters, leaflets and information relating to any relevant support groups or courses. It also has a display 'diabetes museum' to show patients how diabetes care has evolved over the past 100 years. The television in the diabetes reception area displays information relating the staff, services and local support groups in the area. • STHK Ev36 – Welcome to the diabetes centre television displays When accessing the MWL website, there are several features included such as the ability to increase font size, amend colour scheme adjustments and different languages are available. The website is also compatible with screen readers or use of speech recognition software and navigation using the keyboard to support patients accessing information. • STHK Ev37 – MWL website accessibility tool The St Helens diabetes outreach team undertakes drop-in clinics to support vulnerable and homeless patients who may not easily be able to access services in centres such as the YMCA, CGL, Salvation Army and Hope House. They also offer joint review clinics in GP practices or other health care practices for patients who may struggle to attend hospital venues. • STHK Ev38 – Outreach report May 2025 The team offer a diabetes home visit service to patients who are housebound, residing in nursing or residential care or terminally ill (amongst other criteria) so that they can receive diabetes support without having to attend an outpatient appointment. An example of this is a terminally ill		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	patient who was discharged home new to insulin therapy with a potential delayed discharge. The Diabetes Specialist Nurse (DSN) visited the patient at home and communicated daily with the community nursing team/GP to support with insulin dose titration. This prevented a delayed discharged and allowed the patient to receive appropriate treatment and care without having to leave home to attend for a diabetes clinic appointment. The diabetes team use an appointment reminder text messaging service (Netcall) to make it easier for patients to cancel or request a rebook of appointments. Wheelchair access, mobility aids, disabled parking and disabled toilets are available for patients with mobility needs when attending appointments at St Helens and Whiston hospital. The diabetes unit has dedicated space in the reception/waiting area for wheelchair patients to enable them to easily access services, along with a lowered reception desk area so that it easier to communicate with reception staff when needed. The waiting area is designed to be clutter free and easily accessible for patients with guide or assistance dogs, are visually impaired or have reduced mobility e.g. using crutches etc. An example of this could be a patient who is registered blind with significant retinopathy (diabetes eye damage) needing to attend the diabetes unit and using an assistance dog for support. The team has recently taken part in MWL's accessibility assessment programme as well, where how the department communicates with patients and the physical setting are assessed to determine how accessible the service is as whole. The outcome of the assessment was that the service is very accessible and where there are potential barriers, the department is already aware of them and have things in place to support patients and meet their needs. • STHK Ev39 – Accessibility assessment form – Diabetes St Helens and Whiston FV To ensure we are accessible and supportive of patients we will ensure that relatives/carers can accompany patients when required. The team follows Trust policies and utilises the carers passport when required. • STHK Ev40 – Guidance for the support of unpaid carers within Mersey West Lancashire Teaching Hospitals NHS Trust • STHK Ev41 – Carers passport The St Helens young adults diabetes team were awarded the first prize for best overall presentation at the RCP Medicine 2025 Conference, (revolutionising young adult diabetes care: a patient-centred transformation to improve access, engagement and outcomes in one of England's most deprived areas). The team were also winners of the QIC diabetes award 2025 (Patient Care		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Pathway, Secondary, Primary, Specialist or Community Care) with comments from the panel stating; 'St Helen's young adult diabetes service "was a young adult service demonstrating excellent standards on accessibility and holistic care. It is a rapid access service, a mental health assessment, with high technology use and lower recurrent DKA. This is a high impact project which can also be scaled and replicated in young persons' diabetes clinics. This initiative has also demonstrated economic viability and feedback from both patients and healthcare professionals. This service has good visibility and has been recognised by multiple organisations' • STHK Ev42 – RCP blog 2025 As part of EDS22, patients who visited the service were sent a survey with a combination of questions, designed to evidence how patients can access the service, their needs are met, they are free from harm and were allowed to share positive feedback. Throughout the year, 187 surveys were sent to patients with 21 responses being received which equates to an 11% response rate. • STHK Ev04 – STHK EDS22 survey results **Southport and Ormskirk submission** Both the YP and adult diabetes team have a diverse range of patients with differing communication needs. For example, some patients with learning disabilities or neurodiverse requirements choose to solely communicate with their team (outside of face-to-face appointments) via text or email. This allows the patients and/or their carers to contact the service in a way that they feel comfortable and confident. These needs may be known prior to appointments as the individual has transitioned from paediatric services or if the patient is new to the service, then assessments and patient preference will be determined in their initial appointment. The team follows Trust policy regarding the care of people with a learning disability and/or autism. The YP and adult diabetes team check Careflow for any alerts that may be on patients records regarding any communication needs, disabilities and/or impairments. However as previously mentioned, most patients are known to the service from the paediatric diabetes team, so any requirements are often already known to the services. For individuals where English is not their first language, they are offered an appointment with an interpreter. This can be either face-to-face, telephone or video interpreters. This also includes BSL interpreters for D/deaf patients. The teams follow Trust policy regarding meeting the communication needs of patients.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• SO Ev05 – Policy to meet the communication needs of patients (including interpretation, translation and accessible information standard) As part of the service, YP and the adult diabetes team utilise patient information documents created by Diabetes UK. We provide patients and/or their parents/carers with these documents to ensure they are given the most up to date information and advice that is available regarding their diabetes, treatment and care. • SO Ev06 – Newly diagnosed with diabetes • SO Ev07 – Your guide to type 1 diabetes • SO Ev08 – What care to expect if your have type 1 diabetes • SO Ev09 – Eating well with diabetes • SO Ev10 – Diabetes and looking after your feet • SO Ev11 – Food labels made easy • SO Ev12 – Insulin essential guide In addition, the documents used in the service from Diabetes UK are available on their website in alternative formats, to meet patient's individual communication needs. They're available in different languages, easy read, BSL, braille and video format. • SO Ev13 – Diabetes UK information in different languages and formats webpage (Diabetes information in different languages | Diabetes UK) We are also able to signpost to advice and guidance on the Diabetes UK website to support patients around their diabetes and religious events, as well as cultural elements. • SO Ev14 – Ramadan and diabetes • SO Ev15 – Healthier eating: African, Caribbean and South Asian cuisines For patients who are digitally excluded, we will print the relevant documents off and provide them with a hard copy. The YP and adult diabetes team do not have a diabetes centre, so that we can see patients face to face we use the general outpatients' departments at Southport and Ormskirk hospitals for clinic and any adhoc appointments. This limits the options available to have diabetes specific information in the waiting areas. With this in mind the diabetes team have access to trolleys in both of the departments, that are filled with diabetes-specific information and resources for use during clinics. These resources include the Diabetes UK leaflets mentioned above.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	The diabetes team have the opportunity to utilise communication boxes within the general outpatient department for individuals who may have specific communication needs. As previously mentioned in the general information regarding the diabetes clinics, parents, guardians, and carers are able to attend appointments. As and when required the service can utilise health passports and carers passports and follows Trust guidance around unpaid carers guidance as needed. In addition, patients are able to request a chaperone as per Trust policy and request either male or female staff where staff to do so. • SO Ev16 – Guidance for the support of unpaid carers within Mersey West Lancashire Teaching Hospitals NHS Trust • SO Ev17 – Carers passport • SO Ev18 – Health passport • SO Ev19 – Chaperone policy Using the general outpatient departments at both Southport and Ormskirk means that patients who require wheelchair access, use mobility aids such as crutches or walking sticks, those who require hearing loops or quieter areas for consultations are accommodated by the Trust. Longer appointment times are available for individual patients who may require an interpreter or those who have a learning disability and/or autism. For transgender patients we follow the Trust policy. • SO Ev20 – Caring for transgender patients For patients with a learning disability and/or autism, we follow the Trust policy. • SO Ev21 – Policy for the care of people with a learning disability and/or autism Other requirements that the YP and adult diabetes pump team have to consider include individuals who have type 1 diabetes with disordered eating or T1DE. It is also known as diabulimia. Resources are provided via Diabetes UK and the YP team have a diabetes specialist dietitian who can provide support to these individuals as needed. • SO Ev22 – Diabetes UK support for diabulimia webpage (Diabulimia and diabetes | Diabetes UK) • SO Ev23 – T1DE referral form		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	The YP and adult diabetes pump team aim to be accessible to all patients, including those in health inclusion groups, by making any reasonable adjustments as required. Below are some examples of how different health inclusion groups have been supported. Homelessness - A patient who was part of the YP caseload was having issues with an unsuitable living arrangement and pending eviction. When the patient was subsequently moved out of the local area, their diabetes care continued to be provided whilst the individuals new accommodation was found. This included the team providing additional supplies of blood glucose sensors and pump consumables, so their insulin pump therapy was uninterrupted. The YP diabetes nurse and dietitian reviewed the patient in the patient's temporary accommodation and also at the college they were attending. Contact and appointments were arranged via text message as postal options were not available. Drug dependence/Alcohol dependence – A recent patient has been supported with their diabetes management whilst cannabis dependent. They were provided with written information regarding the effects of drugs on their diabetes management and glucose control. They were provided with the opportunity to be referred to local support services. For any patients who may have issues with alcohol dependence, we utilise the Trusts Hospital Alcohol Liaison Team (HALT) and make onward referrals for community support as appropriate. • SO Ev24 – HALT intranet page link (SO Intranet - Hospital Alcohol Liaison Team (HALT)) • SO Ev25 – TREND document For individuals who are included in other health inclusion groups, such as asylum seekers, refugees, sex workers, people in contact with the justice system, victims of modern slavery and Gypsy, Roma and Traveller communities the YP and adult diabetes pump teams would make any necessary adjustments required by the patients in order to establish and maintain open, confidential and effective communication whilst providing and supporting their diabetes care. Where necessary and appropriate to do so, the team will also conduct home visits in order to support patients and meet their needs. The service has recently taken part in MWL's accessibility assessment programme as well, where how the department communicates with patients and the physical setting are assessed to determine how accessible the service is as whole. As the service doesn't have a dedicated setting, the way patients can communicate with department was assessed. The outcome of the assessment was that the department has good practices in place for communicating with patients, with minor actions identified to further strengthen the processes in place.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• S&O Ev 26 - Accessibility assessment form – Diabetes Southport and Ormskirk FV As part of EDS22, patients who visited the service were sent a survey with a combination of questions, designed to evidence how patients can access the service, their needs are met, they are free from harm and were allowed to share positive feedback. Throughout the year, 117 surveys were sent to patients with 8 responses being received which equates to an 7% response rate. • SO Ev03 – S&O EDS22 survey results		
1C: When patients (service users) use the service, they are free from harm	**Whiston and St Helens site submission** As part of their diabetes outpatient clinical consultation, patients are verbally risk assessed for alcohol and smoking status. If appropriate with consent, they can be referred to the trust and/or local smoking cessation team and alcohol support. The team follow the Trust guidelines, screening tools and provide patients with the relevant patient information. • STHK Ev43 – Smoking cessation guideline • STHK Ev44 – Break free from smoking booklet • STHK Ev45 – Smoke free policy • STHK Ev46 – Alcohol, smoking, illicit drugs what you need to know (TREND) • STHK Ev47 – Diabetes my way, alcohol and type 1 diabetes (diabetes my way) During clinical consultations patients are assessed and if appropriate offered a referral to psychology for additional support. Patients who show or express signs of distress can be signposted to the most appropriate wellbeing or support services. • STHK Ev48 – Psychological support options • STHK Ev49 – Flow chart for referral pathway for clinical psychology • STHK Ev50 – Psychology anxiety and physical health conditions leaflet • STHK Ev51 – Clinical psychology information leaflet • STHK Ev52 – Psychology uncertainty and physical health conditions leaflet • STHK Ev53 – Psychology support for traumatic events As previously mentioned, service users are available to request a chaperone to attend their appointment, as well as a male or female member of staff where safe and appropriate to do so as per trust policy. In addition, relatives/carers can accompany patients when required to ensure patient safety during appointments. The team follows Trust policies and utilises the carers passport when required.	3	Diabetes Centre St Helens Diabetes Service Southport and Ormskirk

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• STHK Ev35 – Chaperone policy • STHK Ev40 – Guidance for the support of unpaid carers within Mersey West Lancashire Teaching Hospitals NHS Trust • STHK Ev41 – Carers passport The introduction of the 'Core 10' integrating mental health screening into St Helens young adult's diabetes clinic contributes to service users being free from harm, as it focuses on deprived areas to enhance engagement and outcomes. • STHK Ev54 – DUK 2025 poster Professional interpreters are provided for patients who need them as per Trust policy, to ensure that the information and explanations given to patients are provided by a fully qualified interpreter and that patients are being provided with the correct information. • STHK Ev06 – Policy to meet the communication needs of patients (including interpretation, translation and accessible information standard) The St Helens diabetes outreach team undertakes drop-in clinics to support groups of vulnerable and homeless patients, drug and alcohol dependent patients and travellers; all sessions take place face-to-face in the care homes and centres themselves. The homeless and those affected by drug and alcohol abuse are disproportionately likely to need healthcare, but they can find accessing health services difficult. The outreach team undertake regular clinics to enable individuals to access services in centres such as the YMCA, CGL, Salvation Army and Hope House (previously Teardrops) in the community. They reached the final of the Quality in Care (QIC) diabetes awards in November 2025 and were highly commended for their work. • STHK Ev55 – QIC award application • STHK Ev56 – QIC award certificate The team also offer a diabetes home visit clinic to patients who are housebound, residing in nursing or residential care or terminally ill (amongst over criteria) so that they can receive diabetes support without having to attend an outpatient appointment and maintain patient safety in these settings. All patient safety incidents and near misses are reported as per Trust policies and logged on the Trusts incident reporting system InPhase. All staff within the team are aware to report any patient safety incidents or near misses as required. All appropriate diabetes related incidents are discussed at the monthly diabetes & endocrinology quality and improvement governance meeting		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	and or monthly diabetes & endocrinology safety meeting and escalated as needed to the medicine divisional governance meeting as required. • STHK Ev57 – Incident reporting and management policy • STHK Ev58 – Patient safety incident response policy Trust wide lessons learnt information is shared with staff, to ensure that any learning from trust wide incidents is shared with staff. With daily staff (am/pm) safety huddles also taking place at St Helens hospital diabetes unit and within the Whiston inpatient diabetes team, to reduce the risk of any safety events and to ensure staff on duty aware of any safety concerns or given the opportunity to raise these. • STHK Ev59 – Sharing the lessons learned April 2025 • SHTK Ev60 – Insulin safety bulletin 06.2025 • STHK Ev61 – 5R's 12.2025 • STHK Ev62 – Safety huddle July 2025 STHK final • STHK Ev63 – Safety huddle September 2025 STHK final As part of the team's processes, all governance and patient safety issues including the Trust risk register are discussed at the monthly diabetes & endocrinology quality and improvement governance meeting and diabetes & endocrinology safety meeting. Subspeciality services which form part of the St Helens diabetes team such as the antenatal MDT, foot MDT, diabetes outreach MDT, technology MDT service etc. report via AAA (Alert, Advise, Assure) forms. With any relevant issues reported monthly to the diabetes & endocrinology quality and improvement governance meeting. • STHK Ev64 – New AAA exception report 2025 – inpatient strategy The St Helens diabetes team has achieved accreditation for two elements of its service, (QUISMET) for its delivery of diabetes structured education and the Diabetes Care Accreditation Programme (DCAP) associated with the Royal College of Physicians level 1 for diabetes inpatient care, this supports the delivery of a safe and effective service. • STHK Ev65 – First DCAP accredited service • STHK Ev66 – Quismet accreditation certificate		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	The department takes part in national initiatives such as 'hypo awareness week' and 'insulin safety week' across the Trust, to help promote awareness and patient safety in relation to diabetes care across the Trust. • STHK Ev67 – Hypo awareness week excellence award entry • STHK Ev68 – Insulin safety week excellence award entry The team uses MWL diabetes guidelines in relation to diabetes to reduce the risk of patient harm and uses standardised clinic sheets and pathways, to ensure that patient care is consistent and in line with current guidance and standards • STHK Ev69 – Inpatient DKA management booklet • STHK Ev70 – Whiston and St Helens adult diabetes guidelines • STHK Ev71 – Diabetes consensus document • STHK Ev72 – NPC pathway ver 10b 925 • STHK Ev73 – NPC form ver 10b 925 • STHK Ev74 – NPC standards new ver 2 (NICE) All MWL staff undertake core clinical and mandatory training to ensure that they are aware of Trust procedures and protocols relevant to their role. The diabetes team follow numerous Trust policies to ensure patients are free from harm. • STHK Ev06 – Policy to meet the communication needs of patients (including interpretation, translation and accessible information standard) • STHK Ev57 – Incident reporting and management policy • STHK Ev58 – Patient safety incident response policy • STHK Ev75 – Mental Capacity Act and Deprivation of Liberty Safeguards (DOLs) policy • STHK Ev76 – Medicines policy • STHK Ev77 – Safeguarding adults' policy • STHK Ev78 – Safeguarding children and young people • STHK Ev79 – Infection prevention policy As part of EDS22, patients who visited the service were sent a survey with a combination of questions, designed to evidence how patients can access the service, their needs are met, they are free from harm and were allowed to share positive feedback. Throughout the year, 187 surveys were sent to patients with 21 responses being received which equates to an 11% response rate.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• STHK Ev04 – STHK EDS22 survey results **Southport and Ormskirk submission** Within both the YP and adult diabetes pump services patients are encouraged to bring relatives or carers as needed. For individuals in the YP service who have transitioned from the paediatric team, they are explicitly asked if they still wish for their parents/guardians to be included in any communication. They are often asked in the event the YP Diabetes Specialist Nurse (YPDSN) cannot contact the patient via their chosen method of communication, are they happy for the YPDSN to contact their parents/guardians as well. This is often in relation to general welfare checks or if the patient's parents contact the YPDSN first. As previously mentioned, when required the YP and adult diabetes pump team utilise chaperones, carers and MWL's health passport to ensure patients are free from harm when using the service. • SO Ev16 – Guidance for the support of unpaid carers within Mersey West Lancashire Teaching Hospitals NHS Trust • SO Ev17 – Carers passport • SO Ev18 – Health passport • SO Ev19 – Chaperone policy Patients who use the YP and adult diabetes pump services are risk assessed as appropriate for example, the service use the smoking risk assessment and will refer to local smoking cessation services as required. Although it is an inpatient focussed smoking cessation team, they have resources for outpatient referrals • SO Ev20 – Smoking cessation intranet page link (SO Intranet - Inpatient SmokeFree Service) • SO Ev21 – Smoking cessation guideline All staff within the YP and adult diabetes pump team and the wider diabetes inpatient team have to complete mandatory training which includes safeguarding adults level 2 and safeguarding child level 2. The YPDSN and YP specialist dietitian are required to completed safeguarding children level 3 as they spend time with patients under the age of 16 years. All staff within the YP and adult diabetes pump team and the wider diabetes inpatient team have to complete the Trust mental capacity act level 2 as part of mandatory training. The team also follows the relevant Trust policies around safeguarding.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• SO Ev22 – Mental Capacity Act and Deprivation of Liberty Safeguards (DOLs) policy • SO Ev23 – Safeguarding adults' policy • SO Ev24 – Safeguarding children and young people policy The YP and adult diabetes pump team have good relationships with the safeguarding team. The YP team in particular have a number of young people who have had safeguarding concerns raised when they were children within the paediatric diabetes team. There are instances where they have had to attend best interest's meetings with different agencies (social workers, teachers, carers, other health care professionals) to ensure patients at risk are provided with as much support as required. In the event of any incidents and/or near misses, they are logged and reported as per Trust policy. • SO Ev25 – Incident reporting and management policy • SO Ev26 – Patient safety incident response policy Any incidents that are logged and reported are discussed within the relevant governance meetings (patient safety, medicines management) and they are discussed within the diabetes team business meeting that is held monthly. A new cross site working group for insulin related clinical incidents has been established and due to have the first meeting in February 2026. This is predominantly to discuss inpatient incidents but will provide the opportunity to discuss any incidents involving insulin. The YP and adult pump diabetes team use lots of different diabetes related technology such as different insulin pumps, different insulin pump giving sets/consumables and different continuous blood glucose monitoring devices. As a result, the teams have to act upon any alerts, recalls and safety information regarding these medical devices. These are usually delivered via the Medicines and Healthcare products Regulatory Agency (MHRA), or from the manufacturers directly. • SO Ev27 – MHRA website link (Medicines and Healthcare products Regulatory Agency - GOV.UK) • SO Ev28 – FreeStyle Libre 2 3 plus low readings – HCP letter final • SO Ev29 – FreeStyle Libre 3 3 plus low readings – customer letter Patient choice is a cornerstone of the care provided by the YP and adult diabetes pump teams. Insulin pump contracts are usually renewed every four years, once their warranty has expired (with the exception of the Omnipod 5 system which does not require a four year contract). When a warranty is near to expiry, patients are offered the chance to change their pump if they choose to.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	They are provided with a document that explains the utility of each of the pumps, which CGM sensors are compatible, and any pros and cons associated with the pumps. This is the same document that is provided to patients when they are choosing the first pump they use. Patients are also offered an opportunity to have a face-to-face appointment with their specialist nurse if they wish to see a demonstration pump and get hands on experience before making their choice. • SO Ev30 – Considering an insulin pump 3.0 • SO Ev31 – HCL system information leaflet 2023 Professional interpreters are provided for patients who need them as per Trust policy, to ensure that the information and explanations given to patients are provided by a fully qualified interpreter and that patients are being provided with the correct information and are safe from harm. • SO Ev05 – Policy to meet the communication needs of patients (including interpretation, translation and accessible information standard) As part of EDS22, patients who visited the service were sent a survey with a combination of questions, designed to evidence how patients can access the service, their needs are met, they are free from harm and were allowed to share positive feedback. Throughout the year, 117 surveys were sent to patients with 8 responses being received which equates to an 7% response rate. • SO Ev03 – S&O EDS22 survey results		
1D: Patients (service users) report positive experiences of the service	**Whiston and St Helens site submission** Feedback can be received by the team in several ways such as letters, verbally, thank you cards, emails, thank you forms via the MWL website, via external bodies such as Healthwatch, Friends and Family Test (FFT) and departmental surveys. All feedback and results are discussed in the diabetes and endocrine quality and improvement governance meetings (monthly) – highlighting positive experiences and any actions/lessons learned that can be developed from feedback. Monthly FFT results relating to diabetes & endocrinology are reported, which are typically very positive. • STHK Ev80 – Diabetes centre FFT report, May 2025 • STHK Ev81 – Diabetes centre FFT report, June 2025	3	Diabetes Centre St Helens Diabetes Service Southport and Ormskirk

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Monthly open and honest feedback relating to the diabetes is also published which is typically positive. • STHK Ev81 – Open and honest report, Jan 25 to Dec 25 The team were also winners at the Trust Hospital Annual Awards 2025 for patient choice, nominated by St Helens Star readers. Many patients return feedback through the Ask Rob (chief executive) function, send patient thank you cards or provide verbal positive feedback. • STHK Ev82 – Thank you card 1 • STHK Ev83 – Thank you card 2 • STHK Ev84 – Thank you card 3 Annual diabetes and endocrinology outpatient clinic surveys and inpatient diabetes satisfaction surveys are sent to patients for them to complete which are typically very positive and patients have the ability to report their positive experiences within the service. • STHK Ev85 – Diabetes outpatient clinic survey satisfaction results 2024 to 2025 • STHK Ev86 – Endocrinology clinic satisfaction results 2025 • STHK Ev87 – DN patient survey 2025 presentation Some parts of the service at St Helens hospital undertake clinic evaluation surveys which are typically very positive. • STHK Ev88 – Experience feedback Trust InPhase (compliments system) used to record positive feedback and shared with team and care group at monthly governance and quality improvement meetings. St Helens young adult diabetes service shortlisted for the 2025 Royal College of Physicians Excellence in Patient Care awards and the Quality in Care Diabetes (QIC) awards 2025 final for patient experience. As part of EDS22, patients who visited the service were sent a survey with a combination of questions, designed to evidence how patients can access the service, their needs are met, they are free from harm and were allowed to share positive feedback. Throughout the year, 187		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	surveys were sent to patients with 21 responses being received which equates to an 11% response rate. • STHK Ev04 – STHK EDS22 survey results **Southport and Ormskirk submission** Positive feedback is provided to the team via face-to-face conversations, texts, emails and cards – some examples are provided. The feedback is then shared to the team via email and our business meetings. Compliments can be logged on InPhase/InPraise as well. They can also be added via the Ask Rob facility and send a thank you form. Feedback can also be sent to the patient experience inbox as well. • SO Ev32 – Thank you email 1 • SO Ev33 – Thank you email 2 • SO Ev34 – Thank you card There is also an electronic feedback form available on the Trust website for patients to complete after attending an appointment Patients are also able to scan a QR code during their appointment to provide feedback as well. • SO Ev35 – Diabetes clinic feedback webform (Diabetes Clinic Feedback) We have recently started the process of utilising the Friends and Family Test (FFT) for patients who attend any diabetes related outpatient appointments which includes the YP and adult diabetes pump service. As part of EDS22, patients who visited the service were sent a survey with a combination of questions, designed to evidence how patients can access the service, their needs are met, they are free from harm and were allowed to share positive feedback. Throughout the year, 117 surveys were sent to patients with 8 responses being received which equates to an 7% response rate. • S&O Ev03 – EDS22 survey results		
Domain 1: Commissioned or provided services overall rating (Diabetes and Endocrinology)		**3**	

2.3.2. Radiology Services

Outcome	Evidence	Rating	Owner (Dept/Lead)
1A: Patients (service users) have required levels of access to the service	The MWL Radiology Service operates across all 5 hospital sites; Whiston, St Helens, Newton, Southport and Ormskirk hospitals; as well as community areas in St Helens and Widnes; St Helens Millenium Centre, Lowe House St Helens and Widnes Treatment Centre. The service offers a comprehensive range of imaging technologies to help diagnose and treat diseases, for all our local and wider communities. The service can be accessed for paediatric and adult patients in multiple ways – through internal referrals from the emergency, inpatient or outpatient departments or external referrals via GP and dental. **MWL EDS Accessibility Survey** The Patient Experience & Inclusion (PEI) Team developed a Patient Accessibility Feedback Survey. Patients were sent surveys during Q3 and Q4 2025/26, the PEI Team would randomly select patients from the service lists and send them a survey to complete. The survey is anonymous and available to complete via QR code, online link and paper (with prepaid envelopes to return). The survey questions are centred around accessibility, looking at access, feeling listened to, receiving information, cultural needs etc. The survey also collects demographics looking at age, sex, ethnicity and disability. There was a total of 500 surveys sent to Radiology patients, with a total of 120 returned (24% response rate). The results of the Radiology survey were positive with all questions positive responses being above 90%. Accessing the service – 99% of patients felt they could access the service when they needed to. • ***EV1:*** *Radiology EDS Accessibility Survey Results* The scope of Radiology imaging includes obstetric and general ultrasound scanning, cross sectional imaging - Magnetic Resonance Imaging (MRI), Computed Tomography (CT), fluoroscopy, DEXA scanning, intervention and cardiac catheter lab, breast imaging, nuclear medicine, dental x-rays and general radiography. Radiology is also integral to specific cancer pathways, ensuring that patients receive confirmed diagnoses as part of the 28-day Faster Diagnosis Standard, so treatment can commence within 62 days of an urgent GP referral or screening detection. The Northwest Regional Burns and Plastic Surgery Unit is based at Whiston Hospital, and the Radiology Department works collaboratively with clinical teams from North Wales and the Isle of Man to support imaging for patients referred from these services. This collaborative approach supports seamless cross-regional patient pathways and ensures imaging is delivered safely, efficiently and in line with specialist clinical requirements.	3	MWL Radiology Service

Outcome	Evidence	Rating	Owner (Dept/Lead)
	The Northwest Regional Spinal Injuries Centre is based at Southport District General Hospital and is one of only 8 units in England that specialises in the rehabilitation of patients with spinal cord injuries. The Radiology department supports imaging for those patients who have been transferred into specialist care for ongoing treatment and rehabilitation. The service is accessible to patients of all ages (with ages ranging from one day old to 107 years of age). Our patients come from a variety of ethnic and socio-economic backgrounds, nationalities, diversities and abilities who may require some assistance or adjustments when they access our services –for example interpreters, translations, manual handling aids, reasonable adjustments to patient pathways. We have patients who require interpreters and translated documents (foreign languages and Deaf patients). We have seen patients in same sex relationships, from the travelling community, homeless, drug and alcohol users, patient with learning difficulties/ disabilities such as living with autism, with mental health conditions and patients with religious beliefs regarding the use of Human Serum Albumin for nuclear medicine lung perfusion studies. **Interpreters** Face to face or telephone interpreters are booked for all appointments. Face to face or telephone is used for foreign language patients and face to face is used for BSL, lip reader, Deaf/blind patients. The service does not have an iPad for video interpreting but will use video interpreting when required with the support of the PEI team. Radiology also has a Radiology Interpreter Policy that links to the Trust wide Policy to meet the communication needs of patients as well as a quick guide procedure for non-English speaking patients in MRI, which is in conjunction with Trust policy. • ***EV2:*** *PD0115 Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard)* • ***EV3:*** *Radiology Interpreter Policy* • ***EV4:*** *Procedure for non-English speaking patients in MRI* **Accessible Information Standard** MWL has electronic alerts (alarms on the CRIS system) that are placed on the patient record of patients who require additional communication support due to their disability or impairment. In addition to interpreters, we can translate patient information for foreign language patients or BSL via QR code linked to a signed video. We can also provide patient information in large print, easy read, CD and braille. MWL also has the Communication support for people with disabilities (Accessible Information Standard) Patient Information Leaflet. Radiology also displays the Trust Accessible Information Standard Poster across all sites.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• ***EV2:*** *PD0115 Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard)* • ***EV5:*** *MWL2236 Communication support for people with disabilities (Accessible Information Standard) Patient Information Leaflet* • ***EV6:*** *MWL Accessible Information Standard Poster* **Reasonable Adjustments** Any reasonable adjustments for patients are identified through the alarms system on the CRIS system and adjustments are made. The departments are also flexible to enable adjustments for those patients who don't have an alarm and then present to the department requiring an adjustment. Radiology has a specific Standard Operating Procedure for staff to follow when dealing with patients who have additional needs (including children). • ***EV7:*** *SOP 060 Patients with additional needs in the Radiology department* **MWL Accessibility Assessments (AA)** All Radiology areas across MWL have recently undertaken an Accessibility Assessment by the Patient Experience and Inclusion Team. The AA is intended to be a supportive measure, to allow the Patient Experience & Inclusion (PEI) Team to look at how services function and offer recommendations on how we can improve accessibility for patients, service users or visitors as well as share areas of good practice. There are two elements to this assessment that consist of an initial meeting, walk round of the area (not applicable for areas that are not public facing) and a follow up meeting with a report. The AA looks at two areas communication and physical accessibility. • ***EV8:*** *MWL Accessibility Assessment Guidance Document* • ***EV9:*** *MWL Accessibility Assessment – Radiology Whiston, St Helens and Community areas final report* • ***EV10:*** *MWL Accessibility Assessment – Radiology Southport and Ormskirk areas final report* The system used in Radiology (CRIS) only records sex as male, female and other, unfortunately this is a regional system that cannot be amended locally, but the service has seen patients that are transgender, non-binary etc. For instances where we would have a transgender patient, we would ensure that we follow the Trust policy. We have a Trust Patient Information leaflet regarding changing your name and biological sex on your medical records and a patient poster called "Why am I being asked my registered sex at birth?" • ***EV11:*** *PD0593 Caring for Transgender Patients Policy*		

<table>
<tr><th>Outcome</th><th>Evidence</th><th>Rating</th><th>Owner (Dept/Lead)</th></tr>
<tr><td></td><td>

EV12: MWL2168 Changing your name and biological sex on your medical records Patient Information Leaflet
EV13: “Why am I being asked my registered sex at birth?” Poster

The service records contain demographic information of the service users who attend (gender, age, ethnicity).

EV14: Radiology Service Demographic data slides

Age
<table>
<tr><th></th><th>MWL total</th><th>%</th><th>Whiston, St Helens, Newton sites</th><th>%</th><th>Southport & Ormskirk sites</th><th>%</th></tr>
<tr><td>0-15 years</td><td>18354</td><td>8.2%</td><td>9535</td><td>6.5%</td><td>8819</td><td>11.3%</td></tr>
<tr><td>16-24 years</td><td>13996</td><td>6.2%</td><td>9206</td><td>6.3%</td><td>4790</td><td>6.1%</td></tr>
<tr><td>25-34 years</td><td>24622</td><td>11.0%</td><td>17313</td><td>11.8%</td><td>7309</td><td>9.4%</td></tr>
<tr><td>35-44 years</td><td>26451</td><td>11.8%</td><td>18947</td><td>12.9%</td><td>7504</td><td>9.6%</td></tr>
<tr><td>45-54 years</td><td>27141</td><td>12.1%</td><td>18814</td><td>12.8%</td><td>8327</td><td>10.7%</td></tr>
<tr><td>55-64 years</td><td>37882</td><td>16.9%</td><td>25637</td><td>17.5%</td><td>12245</td><td>15.7%</td></tr>
<tr><td>65-74 years</td><td>34208</td><td>15.2%</td><td>22069</td><td>15.1%</td><td>12139</td><td>15.6%</td></tr>
<tr><td>75-84 years</td><td>29505</td><td>13.1%</td><td>17823</td><td>12.2%</td><td>11682</td><td>15.0%</td></tr>
<tr><td>85-94 years</td><td>11566</td><td>5.2%</td><td>6682</td><td>4.6%</td><td>4884</td><td>6.3%</td></tr>
<tr><td>95-104 years</td><td>722</td><td>0.3%</td><td>414</td><td>0.3%</td><td>308</td><td>0.4%</td></tr>
<tr><td>105 years +</td><td>3</td><td>0.0%</td><td>1</td><td>0.0%</td><td>2</td><td>0.0%</td></tr>
</table>
Sex
<table>
<tr><th></th><th>MWL total</th><th>%</th><th>Whiston, St Helens, Newton sites</th><th>%</th><th>Southport & Ormskirk sites</th><th>%</th></tr>
<tr><td>Male</td><td>107110</td><td>47.7%</td><td>62350</td><td>42.6%</td><td>44760</td><td>57.4%</td></tr>
<tr><td>Female</td><td>117309</td><td>52.3%</td><td>84079</td><td>57.4%</td><td>33230</td><td>42.6%</td></tr>
<tr><td>Other in Unk</td><td>31</td><td>0.0%</td><td>12</td><td>0.0%</td><td>19</td><td>0.0%</td></tr>
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</td><td></td><td></td></tr>
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Outcome	Evidence	Rating	Owner (Dept/Lead)

Ethnicity

	MWL total	%	Whiston, St Helens, Newton sites	%	Southport & Ormskirk sites	%
White British	187485	83.5%	124599	85.1%	62886	80.6%
White Irish	1260	0.6%	920	0.6%	340	0.4%
Any other White background	5147	2.3%	3464	2.4%	1683	2.2%
Mixed White and Black Caribbean	188	0.1%	124	0.1%	64	0.1%
Mixed White and Black	255	0.1%	190	0.1%	65	0.1%
Mixed White and Asian	333	0.1%	228	0.2%	105	0.1%
Mixed Other	1023	0.5%	779	0.5%	244	0.3%
Indian (Asian/Asian British)	780	0.3%	557	0.4%	223	0.3%
Pakistani (Asian/Asian British)	191	0.1%	138	0.1%	53	0.1%
Bangladeshi (Asian/Asian British)	134	0.1%	43	0.0%	91	0.1%
Asian other	794	0.4%	603	0.4%	191	0.2%
Caribbean (Black/Black British)	161	0.1%	121	0.1%	40	0.1%
African (Black/Black British)	620	0.3%	471	0.3%	149	0.2%
Black Other	330	0.1%	265	0.2%	65	0.1%
Chinese	490	0.2%	355	0.2%	135	0.2%
Any Other Ethnic Group	1794	0.8%	1212	0.8%	582	0.7%
Not Stated	23465	10.5%	12372	8.4%	11093	14.2%

Website
MWL website has several features included such as the ability to increase font size, amend colour scheme adjustments, different languages available, screen reader or use of speech recognition software and navigation using the keyboard to support patients accessing information. MWL also has a dedicated page informing people of the accessible support at MWL:

https://sthk.merseywestlancs.nhs.uk/accessibility

Outcome	Evidence	Rating	Owner (Dept/Lead)

	• The Radiology teams across MWL each have dedicated pages for their services, advising patients on accessing the service (locations, opening times, wait times, patient information leaflets, procedures etc.)
	  ○ Whiston, St Helens and Newton Radiology page https://sthk.merseywestlancs.nhs.uk/our-services?service=38
	  ○ Southport and Ormskirk Radiology page https://so.merseywestlancs.nhs.uk/our-services?service=22
	
	Accessibility bar at the top of MWL homepage:
	 
	
	For outpatient appointments, patients are sent letters, and we have an appointment reminder text service as well as the ability to cancel or reschedule appointments online. Radiology has its own appointments team that are contactable via telephone – details of which are on all patient letters and the radiology webpages. At Whiston, St Helens and Community sites the admin team can also be contacted via email for any appointments, general queries or information on reports, this information is shared on the appointment letters and webpage - xray.appointment@merseywestlancs.nhs.uk /xray.reports@merseywestlancs.nhs.uk
	
	Following the Accessibility Assessment, Southport and Ormskirk Radiology team are currently in the process of setting up an email contact for patients with the admin team. This will enable all patients to contact the department if they have any queries as an alternative method to face to face and telephone. It will also ensure the department provides a contact method for non-verbal patients to contact the department.
	
	• ***EV15:*** *Example Radiology letter – Whiston, St Helens and Community Services*
	• ***EV16:*** *Example Radiology letter – Southport and Ormskirk*
	
	Wheelchair access, mobility aids (stand aid, banana board, slide sheets and hoists) and disabled parking is available for patients with mobility needs.
	
	Examples of reasonable adjustments in Radiology
	Autism – CT Imaging - For a patient living with autism who required a CT scan, the following reasonable adjustments were made:
	• A pre-appointment discussion was held to understand the patient's specific needs, triggers and communication preferences.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Appointment timing was adjusted to reduce waiting times and avoid peak departmental activity. • A quiet environment was maintained within the Radiology Day Case ward to minimise sensory overload. • Family members were permitted to remain with the patient throughout the process, including one family member in the CT scan room during the examination providing reassurance and familiarity. • Clear, simple explanations were given, with reassurance at each stage of the examination. • Individual needs were documented on CRIS and electronic alert systems to ensure continuity of care for future attendances. **Autism with Claustrophobia** – MRI Imaging - For an autistic patient with significant claustrophobia requiring MRI imaging: • Claustrophobia pathway was initiated following assessment by clinicians referring patient for the scan. • Radiology staff liaise closely with the Trust LD Specialist Nurse. Options such as environmental familiarisation, desensitisation and support persons were considered however due to the severity of anxiety and sensory distress, it was identified that reasonable adjustments alone would not enable the patient to tolerate the scan safely. • The patient was therefore referred for MRI under full anaesthesia in line with Trust policy, following multidisciplinary discussion, ensuring the scan could be completed safely and compassionately. • Individual needs were documented on CRIS and electronic alert systems to ensure continuity of care for future attendances. **Fetal Alcohol Syndrome -** A paediatric patient with **Fetal Alcohol Syndrome** attended for a nuclear medicine study. The patient experiences significant anxiety and sensory sensitivity, requiring **specialist reasonable adjustments** to support safe and successful imaging. To reduce distress and the need for sedation: • A **play specialist** was involved pre-procedure to explain the scan in a child-appropriate way • **Distraction techniques** were used throughout the procedure • **Topical anaesthetic (e.g. ELMA/Ametop)** was applied prior to cannulation • Cannulation was performed using a **child-centred, low-stimulus approach** • Additional time was allocated to prevent rushing and reduce anxiety These adjustments enabled **successful cannulation of the scan** while maintaining patient dignity, safety and comfort. **Wheelchair User from Care Home Requiring Hoist in Dexa scan –** following reasonable adjustments made: • Patient needs identified through alerts on CRIS system when booking appointment.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Double appointment slot booked at end of morning session ensuring protected time for scan to take place • Ensures enough staff to hoist patient safely and with dignity and respect • Carers able to come into Xray room with patient before scan, to reassure them and ensure they feel safe and comfortable to proceed • Radiographer continually talks to patient throughout procedure, providing reassurance, ensuring they are happy to continue at each stage of the scan • Carers able to return to room once scan completed, providing comfort and support to patient • Radiographer assembles team for hoisting patient back into wheelchair, safely and securely • Patient transport booked with admin team as soon as possible, to ensure waiting times for transport home kept to an absolute minimum • Any other individual needs documented on CRIS for future reference for continuity of care **Paediatric Patient with LD having an Ultrasound scan –** the following reasonable adjustments were made: • In-depth discussion with parent/carer to determine best approach to undertake for successful outcome, prior to appointment and an understanding of specific needs and potential barriers discussed • Longer appointment time given to enable quiet and calming atmosphere • Appointment made at end of school day to fit in with educational needs • A run-through of what will happen during examination, demonstrating procedure with patients' soft toy (teddy bear/doll) initially • Lighting kept to a low level so patient and carer can see Sonographer clearly (usually room is dark) • Children's night light with projector used, playing soft music and scattering themed shapes onto room walls, providing a calming ambience in ultrasound room • Parent/carer providing reassurance to child throughout scan • Clear, simple instructions given, with reassurance at each stage of the scan • Individual needs were documented on CRIS to ensure continuity of care for future attendances		
1B: Individual patients (service users) health needs are met	**MWL EDS Accessibility Survey** 1. **Feeling listened to** – 100% of patients felt they were listened to by the team. 2. **Information** – 96% of patients felt they received enough information about their condition/treatment to help them make an informed choice about their care. 3. **Asking questions** – 100% of patients felt their questions were answered in a way they could understand. 4. **Cultural needs** – 97% of patients felt their cultural needs were taken into consideration. 5. **Social needs** – 96% of patients felt their social needs were taken into consideration. • ***EV1:*** *Radiology EDS Accessibility Survey Results*	3	MWL Radiology Service

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Before any appointment in the department, the teams review patient alarms on the CRIS system to ensure they are meeting any reasonable adjustments the patient may require. The admin team will also ensure that interpreters have been arranged for patients when the appointment is scheduled and confirm this with the team before the patient arrives for their appointment. Radiology offers a variety of appointment times to meet patients' needs (early/evening/weekend appointments), all sites have hearing loops, and the department has a specific Standard Operating Procedure (SOP60) for staff to follow when dealing with patients who have additional needs (including children). • ***EV7:*** *SOP 060 Patients with additional needs in the Radiology department* **Patient Assessments / Safety checks** Formal assessments are carried out at each Radiology visit. Staff identify additional support needs, including physical, cognitive, communication, or sensory requirements and implement reasonable adjustments as required. All modalities have their own safety questionnaires. • ***EV17:*** *Example - MR Safety Questionnaire* • ***EV18:*** *Example - Pre-Contrast CT Examination Safety Questionnaire* • ***EV19:*** *Example - CT Coronary Angiography Safety Questionnaire* • ***EV20:*** *Example - CT Colonography Safety Questionnaire* • ***EV21:*** *Pause & Check Poster* **Carers / Relatives / Chaperones** Carers can accompany and support patients when needed to ensure we are accessible and supportive of patients. This is managed in line with **Employer's Procedure (n) – Procedure for Dealing with Individuals Who Care or Comfort**, which allows carers to be present where this supports the patient's wellbeing, safety and ability to undergo the examination, while ensuring radiation and MRI safety requirements are met. The team follows Trust policies and utilises the carers passport when required. • ***EV22:*** *(n) Procedure for Dealing with Individuals who Care or Comfort* • ***EV23****: Carer and comforters in nuclear medicine Patient Information Leaflet (PIL)* • ***EV24:*** *SOP104 Radiology Chaperone Policy* • ***EV25:*** *Guidance for the support of unpaid carers within Mersey West Lancashire Teaching Hospitals NHS Trust Policy* • ***EV26:*** *Cheshire & Merseyside Regional Carer Passport* **Communication Boxes**		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	All areas in Radiology have MWL communication boxes in their areas to support patients with any communication needs. The boxes contain the below information, and they also have an intranet page for staff to use – the intranet page also holds foreign language communication cards to be used with patients. **Contents:** Communication guide / Communication cards / 'I am deaf' cards / Interpreter booking guidance including a language ID tool and telephone interpreting information / Carer passport / Carer card / Magnifying sheet / Dementia top tips / Hearing aid boxes / Health passports / Operation courage information (mental health support for veterans and armed forces). **Transgender patients** MWL has a **Trust wide 'Caring for Transgender Patients'** in place to ensure that **transgender men, transgender women and non-binary patients** are cared for safely, respectfully and in line with best practice. Radiology staff are expected to always follow this policy as well as adhering to the SCoR (Royal Society & College of Radiographers) Impact of Ionising Radiation (Medical Exposure) Regulations 2017 on pregnancy checking procedures. The Employees Procedures are detailed in schedule 2 of the regulations which ensure the safe use of ionizing radiation and 1(c) documents the procedure to establish whether an individual may be pregnant or breastfeeding. This is asked of all patients, in a sensitive and appropriate manner, irrespective of any demographic markers that are recorded on the Radiology Information System (CRIS). This ensures compliance with IR(ME)R 2017 and safeguarding standards. • ***EV11:*** *PD0593 - Caring for Transgender Patients* • ***EV27:*** *The impact of IR(ME)R 2017 IR(ME)R (NI) 2018 on pregnancy checking procedures* **Learning Disability (LD) / Neurodiverse patients** We adapt our communication to the patient's level of understanding, using simple language, visual cues, reassurance and a calm, step-by-step approach. The aim is always to reduce anxiety, ensure consent and help the patient understand *what will happen*, *how it will feel*, and *what they need to do.* Radiology works closely with the Trust's Learning Disability / Autism Nurse Speciality Team to ensure that patients with learning disabilities receive safe, person-centred and well-coordinated imaging care. The LD/Autism Nurse Specialists provide expert support in assessing each patient's individual needs, communication requirements and reasonable adjustments. Where required, they assist in organising **sedation**, **general anaesthetic (GA)** pathways, or additional support measures to ensure patients can tolerate imaging procedures safely and comfortably. This collaborative approach ensures that: • Appropriate preparations are made well in advance of the appointment • Patients and carers understand what will happen using accessible information		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Reasonable adjustments are in place (e.g., pre-visit scanner familiarisation, quiet waiting spaces and extended appointment times) • Clear communication is maintained between Radiology, anaesthetics, LD services and referring teams This joint working supports high-quality, equitable access to imaging for patients with learning disabilities and aligns with national best-practice recommendations. The Radiology team ensure to follow all Trust policies and procedures relating to patients with a learning disability and/or autism, as well as policies relating to patients' communication needs, carer support etc. • ***EV2:*** *PD0115 Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard)* • ***EV28:*** *PD0405 Policy for the Care of People with a Learning Disability and/or Autism* • ***EV29:*** *PD2021 Implementation of Orange Wristband to identify Reasonable Adjustments for Patients with a Learning Disability or Autism* • ***EV30:*** *MWL Health passport* **Interpreters** For patients who require interpretation, face to face or telephone interpreters are booked for all appointments. Face to face or telephone is used for foreign language patients and face to face or video is used for BSL, lip reader and deaf/blind patients. A Departmental mobile phone is used for the interpreting services with the speakerphone function; this allows for improved and confidential communication. This is a dial up service so can be used at any time and is particularly useful in emergencies or when a service user arrives between scheduled appointments; ensuring that the health needs of the individual are fully met. Radiology has produced a **separate, specialty-specific policy** that sits alongside the Trust-wide policy to support Radiology staff in meeting the communication needs of patients. It supports staff by setting out how to access interpreting and translation services for patients who experience communication barriers, including those whose first language is not English or who have sensory (hearing or visual) or other communication needs. This ensures local radiology processes align with the Trust's *Policy to Meet the Communication Needs of Patients (including Interpretation, Translation and the Accessible Information Standard)* while reflecting the practical requirements of imaging services. The team also have Radiology bulletins to share information within the department – example of sharing best practice with Deaf patients. • ***EV2:*** *PD0115 Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard)* • ***EV3:*** *Radiology Interpreter Policy* • ***EV4:*** *Procedure for non-English speaking patients in MRI*		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Accessible Information Standard MWL has electronic alerts that are placed on the Electronic Patient Record (EPR) of patients who require additional communication support due to their disability or impairment. In addition to interpreters, we can translate patient information for foreign languages or BSL via QR code linked to a signed video. We can also provide patient information in large print, easy read, CD and braille. • ***EV2:*** *PD0115 Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard)* • ***EV5:*** *MWL2236 Communication support for people with disabilities (Accessible Information Standard) Patient Information Leaflet* • ***EV6:*** *MWL Accessible Information Standard Poster* **Electronic alerts (alarms) on the Radiology CRIS system** are automatically pulled through from the Electronic Patient Record (EPR). In addition to these automatic imports, the system also provides functionality for Radiology staff to manually input or update any omitted alerts. This ensures that key safety information (e.g., pregnancy status, allergies, infection control flags, safeguarding alerts) are accurately captured and visible at the point of imaging, supporting safe decision-making and compliance with Trust and IR(ME)R requirements. **Patient Information** Radiology has over 50 Patient Information Leaflets (PIL) to inform patients of all ages what to expect when they are having a procedure. MWL can translate patient information leaflets for foreign languages or BSL via QR code linked to a signed video. We can also provide patient information in large print, easy read, CD and braille. 'Pregnant or think that you could be?' posters are displayed in the department translated into multiple foreign languages. Radiology leaflets webpage – https://sthk.merseywestlancs.nhs.uk/patient-information-leaflets?letter=R • ***EV2:*** *PD0115 Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard)* • ***EV31:*** *Radiology Pregnancy Poster* Examples of Radiology Patient Information Leaflets: • ***EV32:*** *Computed Tomography (CT) scan information for children & parents / legal guardians PIL* • ***EV33:*** *Having an X-Ray PIL* • ***EV34:*** *Having an Obstetric Ultrasound PIL*		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	MWL Website MWL website has several features included such as the ability to increase font size, amend colour scheme adjustments, different languages available, screen reader or use of speech recognition software and navigation using the keyboard to support patients accessing information. MWL also has a dedicated page informing people of the accessible support at MWL: https://sthk.merseywestlancs.nhs.uk/accessibility • The Radiology teams across MWL each have dedicated pages for their services, advising patients on accessing the service (locations, opening times, wait times, patient information leaflets, procedures etc.) **Appointments** The Radiology Appointments Team make every effort to book patients at the imaging location closest to their home address. Where clinically appropriate, the team also coordinates multiple appointments on the same day to reduce the number of hospital visits and improve patient convenience for example, if a patient has an OPD appointment on a certain date and has an appointment for an Xray on another date, we will change the date so that the patient can attend for both appointments at the same visit. **MWL Accessibility Assessments (AA)** All Radiology areas across MWL have recently undertaken an Accessibility Assessment by the Patient Experience and Inclusion Team. The AA is intended to be a supportive measure, to allow the Patient Experience & Inclusion (PEI) Team to look at how services function and offer recommendations on how we can improve accessibility for patients, service users or visitors as well as share areas of good practice. There are two elements to this assessment that consist of an initial meeting, walk round of the area (not applicable for areas that are not public facing) and a follow up meeting with a report. The AA looks at two areas communication and physical accessibility. • ***EV8:*** *MWL Accessibility Assessment Guidance Document* • ***EV9:*** *MWL Accessibility Assessment – Radiology Whiston, St Helens and Community areas final report* • ***EV10:*** *MWL Accessibility Assessment – Radiology Southport and Ormskirk areas final report* **Radiology Networks** The Radiology service works in partnership with regional and national professional networks to influence practice, improve safety and reduce health inequalities for people with protected characteristics and other groups at risk across the diagnostic pathway. This includes active engagement with organisations such as the Royal College of Radiologists, College of Radiographers, British Society of Interventional Radiology, Merseyside and Cheshire Cancer Network, Society of Radiographers, and the British Medical Ultrasound Society.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Through these forums, safety standards, clinical guidance, consent processes, communication needs (including learning disability, sensory impairment and language support), workforce education and service accessibility are discussed, developed and shared. Learning from these networks informs local policies, patient information materials, training programmes and quality improvement activity, supporting consistent, inclusive and evidence-based care across services where pathways connect regionally and nationally. The Quality & Accreditation Lead Radiographer and Radiology Governance Lead are active members of the Society of Radiographers 'Radiation Protection Special Interest Group' the group has been set up to encourage learning and CPD and help members ensure their sites are compliant with regulations. Provide a forum where members can ask for advice or provide information on how they have tackled issues. This could improve consistency across sites in how regulations are approached. Learning through others. • ***EV35:*** *Example CAMRIN Workforce Round up* • ***EV36:*** *Example CAMRIN Workforce Newsletter* **Examples of reasonable adjustments in Radiology** **Autism – CT Imaging** - For a patient living with autism who required a CT scan, the following reasonable adjustments were made: • A pre-appointment discussion was held to understand the patient's specific needs, triggers and communication preferences. • Appointment timing was adjusted to reduce waiting times and avoid peak departmental activity. • A quiet environment was maintained within the Radiology Day Case ward to minimise sensory overload. • Family members were permitted to remain with the patient throughout the process, including one family member in the CT scan room during the examination providing reassurance and familiarity. • Clear, simple explanations were given, with reassurance at each stage of the examination. • Individual needs were documented on CRIS and electronic alert systems to ensure continuity of care for future attendances. **Autism with Claustrophobia** – MRI Imaging - For an autistic patient with significant claustrophobia requiring MRI imaging: • Claustrophobia pathway was initiated following assessment by clinicians referring patient for the scan. • Radiology staff liaise closely with the Trust LD Specialist Nurse. Options such as environmental familiarisation, desensitisation and support persons were considered however due to the severity of anxiety and sensory distress, it was identified that reasonable adjustments alone would not enable the patient to tolerate the scan safely.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• The patient was therefore referred for MRI under full anaesthesia in line with Trust policy, following multidisciplinary discussion, ensuring the scan could be completed safely and compassionately. • Individual needs were documented on CRIS and electronic alert systems to ensure continuity of care for future attendances. **Fetal Alcohol Syndrome -** A paediatric patient with **Fetal Alcohol Syndrome** attended for a nuclear medicine study. The patient experiences significant anxiety and sensory sensitivity, requiring **specialist reasonable adjustments** to support safe and successful imaging. To reduce distress and the need for sedation: • A **play specialist** was involved pre-procedure to explain the scan in a child-appropriate way • **Distraction techniques** were used throughout the procedure • **Topical anaesthetic (e.g. ELMA/Ametop)** was applied prior to cannulation • Cannulation was performed using a **child-centred, low-stimulus approach** • Additional time was allocated to prevent rushing and reduce anxiety These adjustments enabled **successful cannulation of the scan** while maintaining patient dignity, safety and comfort. **Wheelchair User from Care Home Requiring Hoist in Dexa scan –** following reasonable adjustments made: • Patient needs identified through alerts on CRIS system when booking appointment. • Double appointment slot booked at end of morning session ensuring protected time for scan to take place • Ensures enough staff to hoist patient safely and with dignity and respect • Carers able to come into Xray room with patient before scan, to reassure them and ensure they feel safe and comfortable to proceed • Radiographer continually talks to patient throughout procedure, providing reassurance, ensuring they are happy to continue at each stage of the scan • Carers able to return to room once scan completed, providing comfort and support to patient • Radiographer assembles team for hoisting patient back into wheelchair, safely and securely • Patient transport booked with admin team as soon as possible, to ensure waiting times for transport home kept to an absolute minimum • Any other individual needs documented on CRIS for future reference for continuity of care **Paediatric Patient with LD having an Ultrasound scan –** the following reasonable adjustments were made: • In-depth discussion with parent/carer to determine best approach to undertake for successful outcome, prior to appointment and an understanding of specific needs and potential barriers discussed		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Longer appointment time given to enable quiet and calming atmosphere • Appointment made at end of school day to fit in with educational needs • A run-through of what will happen during examination, demonstrating procedure with patients' soft toy (teddy bear/doll) initially • Lighting kept to a low level so patient and carer can see Sonographer clearly (usually room is dark) • Children's night light with projector used, playing soft music and scattering themed shapes onto room walls, providing a calming ambience in ultrasound room • Parent/carer providing reassurance to child throughout scan • Clear, simple instructions given, with reassurance at each stage of the scan • Individual needs were documented on CRIS to ensure continuity of care for future attendances		
1C: When patients (service users) use the service, they are free from harm	**MWL EDS Accessibility Survey** 1. **Feeling listened to** – 100% of patients felt they were listened to by the team. 2. **Information** – 96% of patients felt they received enough information about their condition/treatment to help them make an informed choice about their care. 3. **Asking questions** – 100% of patients felt their questions were answered in a way they could understand. 4. **Cultural needs** – 97% of patients felt their cultural needs were taken into consideration. 5. **Social needs** – 96% of patients felt their social needs were taken into consideration. • ***EV1:*** *Radiology EDS Accessibility Survey Results* **Alcohol and Smoking Assessments** All inpatients are risk assessment for alcohol and smoking during their initial assessment in the Trust. Although this is not carried out by the Radiology team, the staff are aware of the relevant services within the Trust and the Break-free from smoking patient information leaflet and smoke free policy. • ***EV37:*** *Break-free from smoking booklet* • ***EV38:*** *PD034 - Smoke free policy* • ***EV39:*** *Smoking Cessation Guidance* **Carers / Relatives / Chaperones** Carers can accompany and support patients when needed to ensure we are accessible and supportive of patients *(example Autism – CT Imaging 1B).* This is managed in line with **Employer's Procedure (n) – Procedure for Dealing with Individuals Who Care or Comfort**, which allows carers to be present where this supports the patient's wellbeing, safety and ability to undergo the examination, while ensuring radiation and MRI safety requirements are met. The team follows Trust policies and utilises the carers passport when required.	3	MWL Radiology Service

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• ***EV22:*** *(n) Procedure for Dealing with Individuals who Care or Comfort* • ***EV24:*** *SOP104 Radiology Chaperone Policy* • ***EV25:*** *Guidance for the support of unpaid carers within Mersey West Lancashire Teaching Hospitals NHS Trust Policy* • ***EV26:*** *Cheshire & Merseyside Regional Carer Passport* **Transgender patients** MWL has a **Trust wide 'Caring for Transgender Patients'** in place to ensure that **transgender men, transgender women and non-binary patients** are cared for safely, respectfully and in line with best practice. Radiology staff are expected to always follow this policy as well as adhering to the SCoR (Royal Society & College of Radiographers) Impact of Ionising Radiation (Medical Exposure) Regulations 2017 on pregnancy checking procedures. The Employees Procedures are detailed in schedule 2 of the regulations which ensure the safe use of ionizing radiation and 1(c) documents the procedure to establish whether an individual may be pregnant or breastfeeding. This is asked of all patients, in a sensitive and appropriate manner, irrespective of any demographic markers that are recorded on the Radiology Information System (CRIS). This ensures compliance with IR(ME)R 2017 and safeguarding standards. • ***EV11:*** *PD0593 - Caring for Transgender Patients* • ***EV27:*** *The impact of IR(ME)R 2017 IR(ME)R (NI) 2018 on pregnancy checking procedures* **Learning Disability (LD) / Neurodiverse patients** Radiology works closely with the Trust's Learning Disability / Autism Nurse Speciality Team to ensure that patients with learning disabilities receive safe, person-centred and well-coordinated imaging care. The LD/Autism Nurse Specialists provide expert support in assessing each patient's individual needs, communication requirements and reasonable adjustments. Where required, they assist in organising **sedation**, **general anaesthetic (GA)** pathways, or additional support measures to ensure patients can tolerate imaging procedures safely and comfortably. This joint working supports high-quality, equitable access to imaging for patients with learning disabilities and aligns with national best-practice recommendations. The Radiology team ensure to follow all Trust policies and procedures relating to patients with a learning disability and/or autism, as well as policies relating to patients' communication needs, carer support etc. • ***EV2:*** *PD0115 Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard)* • ***EV28:*** *PD0405 Policy for the Care of People with a Learning Disability and/or Autism* • ***EV29:*** *PD2021 Implementation of Orange Wristband to identify Reasonable Adjustments for Patients with a Learning Disability or Autism* • ***EV30:*** *MWL Health passport*		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Interpreters For patients who require interpretation, face to face or telephone interpreters are booked for all appointments. Face to face or telephone is used for foreign language patients and face to face or video is used for BSL, lip reader and deaf/blind patients. A Departmental mobile phone is used for the interpreting services with the speakerphone function; this allows for improved and confidential communication. This is a dial up service so can be used at any time and is particularly useful in emergencies or when a service user arrives between scheduled appointments; ensuring that the health needs of the individual are fully met. Radiology has produced a **separate, specialty-specific policy** that sits alongside the Trust-wide policy to support Radiology staff in meeting the communication needs of patients. It supports staff by setting out how to access interpreting and translation services for patients who experience communication barriers, including those whose first language is not English or who have sensory (hearing or visual) or other communication needs. This ensures local radiology processes align with the Trust's *Policy to Meet the Communication Needs of Patients (including Interpretation, Translation and the Accessible Information Standard)* while reflecting the practical requirements of imaging services. The team also have Radiology bulletins to share information within the department – example of sharing best practice with Deaf patients. • ***EV2:*** *PD0115 Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard)* • ***EV3:*** *Radiology Interpreter Policy* • ***EV4:*** *Procedure for non-English speaking patients in MRI* **Accessible Information Standard** MWL has electronic alerts that are placed on the Electronic Patient Record (EPR) of patients who require additional communication support due to their disability or impairment. In addition to interpreters, we can translate patient information for foreign languages or BSL via QR code linked to a signed video. We can also provide patient information in large print, easy read, CD and braille. • ***EV2:*** *PD0115 Policy to meet the communication needs of patients (including interpretation, translation and Accessible Information Standard)* • ***EV5:*** *MWL2236 Communication support for people with disabilities (Accessible Information Standard) Patient Information Leaflet* • ***EV6:*** *MWL Accessible Information Standard Poster* **Electronic alerts (alarms) on the Radiology CRIS system** are automatically pulled through from the Electronic Patient Record (EPR). In addition to these automatic imports, the system also provides functionality for Radiology staff to manually input or update any omitted alerts. This ensures that key safety information (e.g.,		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	pregnancy status, allergies, infection control flags, safeguarding alerts) are accurately captured and visible at the point of imaging, supporting safe decision-making and compliance with Trust and IR(ME)R requirements. **Radiology Networks** The Radiology service works in partnership with regional and national professional networks to influence practice, improve safety and reduce health inequalities for people with protected characteristics and other groups at risk across the diagnostic pathway. This includes active engagement with organisations such as the Royal College of Radiologists, College of Radiographers, British Society of Interventional Radiology, Merseyside and Cheshire Cancer Network, Society of Radiographers, and the British Medical Ultrasound Society. Through these forums, safety standards, clinical guidance, consent processes, communication needs (including learning disability, sensory impairment and language support), workforce education and service accessibility are discussed, developed and shared. Learning from these networks informs local policies, patient information materials, training programmes and quality improvement activity, supporting consistent, inclusive and evidence-based care across services where pathways connect regionally and nationally. The Quality & Accreditation Lead Radiographer and Radiology Governance Lead are active members of the Society of Radiographers 'Radiation Protection Special Interest Group' the group has been set up to encourage learning and CPD and help members ensure their sites are compliant with regulations. Provide a forum where members can ask for advice or provide information on how they have tackled issues. This could improve consistency across sites in how regulations are approached. Learning through others. • ***EV35:*** *Example CAMRIN Workforce Round up* • ***EV36:*** *Example CAMRIN Workforce Newsletter* **Digital Solutions** iRefer, developed by the Royal College of Radiologists, supports patient safety by promoting evidence-based, clinically justified imaging referrals in line with national guidance. Its use helps reduce unnecessary or inappropriate imaging, minimises avoidable exposure to ionising radiation—particularly for vulnerable patient groups—reduces variation in referral practice, and improves diagnostic pathways by ensuring the most appropriate investigation is selected first time. iRefer also supports referrer education and strengthens governance by providing assurance that referrals align with recognised national standards and IR(ME)R requirements. **Patient Information Leaflets (PIL)**		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Patient information leaflets are a key patient-safety control within imaging services, supporting informed consent, appropriate preparation and safe post-examination care. By providing clear, accessible information on procedure expectations, preparation requirements, radiation or contrast risks and aftercare advice, leaflets reduce the risk of cancelled or repeated examinations, unnecessary exposure and avoidable harm. Importantly, patient information leaflets support inclusive and patient-centred care. Accessible formats, plain language, visual aids and signposting to interpreter services help ensure that communication needs are met, reducing the risk of misunderstanding and inequity in care. This aligns with the Accessible Information Standard and reinforces a culture of openness, safety and respect. They also support inclusive communication by addressing individual information needs and promoting patient understanding, confidence and trust. Collectively, patient information leaflets strengthen safe, effective and patient-centred imaging practice in line with regulatory and quality standards. • ***EV32:*** *Computed Tomography (CT) scan information for children & parents / legal guardians PIL* • ***EV33:*** *Having an X-Ray PIL* • ***EV34:*** *Having an Obstetric Ultrasound PIL* **Radiology Bulletins** The team have monthly bulletins that are shared with all Radiology staff regarding feedback on recently received incidents, complaints and compliments received into the Radiology Department across all sites. The bulletins also share information on procedures, systems, infection control and lessons learned etc. – it is important to ensure that all staff continue to review and improve processes to ensure they provide the best possible service to patients that is free from harm. • ***EV40:*** *Example of Radiology Bulletin (1)* • ***EV41:*** *Example of Radiology Bulletin (2)* **Radiology Internal Audits** The Department conduct internal audits regarding safety practices, devices and documentation. This information is shared on the quality notice boards within the department. This ensures that management are cascading to staff, so they are aware of audit results, lessons learned etc. • ***EV42:*** *Example of Radiology Audit Results Poster* **IR(ME)R Clinical Audit and Patient Safety**		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	IR(ME)R clinical audits are undertaken within Radiology to safeguard patients by ensuring that all medical exposures to ionising radiation are clinically justified, optimised and delivered safely. Audits focus on safety-critical controls including appropriate referral and justification, operator and practitioner entitlement and training, clear patient identification, effective communication and consent, dose optimisation against diagnostic reference levels, and the prevention and management of accidental or unintended exposures. Audit outcomes are reviewed through established Radiology governance processes, with targeted actions implemented to mitigate risk and re-audit used to confirm improvement, providing ongoing assurance that patient safety remains central to the delivery of imaging services. • ***EV43:*** *IR(ME)R audit schedule 2025* **Radiology Team Courses / Awards** The Radiology staff attend several courses relating to patient safety, such as leadership courses, avoiding error in CSR reporting course, adult chest reporting course, imaging courses, accreditations etc. The Radiology team have won a number of awards: • Quality Improvement Award MWL staff awards 2025 • Dr Vamsi Rachapalli -Consultant Radiologist - MWL trust employee of the month. • Northwest team of the Year (CT) SOR • Awarded the QSI Quality Mark. • ***EV44:*** *Example list of staff courses* **National Assessments** **Getting It Right First Time (GIRFT)** - is a national clinically led programme that aims to improve the quality, consistency and efficiency of care by reviewing how health services are delivered. It combines comprehensive data analysis with expert input from senior clinicians to assess current practice and identify opportunities for improvement. Interventional radiology across MWL was assessed in August 2025. • ***EV45:*** *GIRFT Report* • ***EV46:*** *GIRFT feedback word clouds* **CQC assessments** Radiology services at St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) have been subject to two Care Quality Commission (CQC) IR(ME)R inspections, both undertaken on a non-reactive basis, covering Radiology and Nuclear Medicine services. The inspections assessed compliance with statutory requirements for the safe use of ionising radiation. Feedback from the CQC was highly positive, providing strong assurance that robust governance, policies, staff training and operational practices are in place and that services are delivering safe, compliant care.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Governance Board The Department have governance boards in the department that are updated each month. The boards display the number of incidents, Trust and department top 3 risks, top 3 incidents, number of falls, radiation incidents, complaints, mandatory training, compliments, staff feedback and shared learning/lessons learned. • ***EV47:*** *Example of department governance board* **Radiology Policies** The Radiology Department has a total of 100 Policies, SOPs and Guidelines. All patient safety incidents and near misses are reported following Trust policies and logged on the Trusts incident reporting system InPhase. All staff within the team report any patient safety incidents or near misses as required. All governance and patient safety issues are discussed at the Radiology Management Team Meeting. Some examples of Radiology policies that relate to patient safety: **Radiology Employers Procedures (a-p)** Are designed to keep patients safe by defining clear roles for **referrer, practitioner and operator** to ensure every exposure to ionising radiation is **justified and optimised**. They ensure only appropriately trained and entitled staff perform examinations. Prevent unnecessary or incorrect radiation exposure. • ***EV48:*** *(a) Procedure to Correctly Identify an Individual for Imaging* • ***EV49:*** *(b) Procedure to Identify Referrers, Practitioners and Operators* • ***EV50:*** *(c) Procedure for Making Enquiries of Individuals of Childbearing Potential* • ***EV51:*** *(d) Radiology Quality Assurance of Patient Dose and Administered Activity* • ***EV52:*** *(e) Procedure for Assessment of Patient Dose and Administered Activity* • ***EV53:*** *(f) Procedure for the Established Review and use of DRLs and Dose Audits* • ***EV54:*** *(g) Procedure for Research Programmes in Radiology* • ***EV55:*** *(h) Procedure for Giving of Information and Written Instructions* • ***EV56:*** *(i) Procedure for Informing Individual Prior to Exposure* • ***EV57:*** *(j) Procedure for Recording of Clinical Evaluation* • ***EV58:*** *(k) Procedure for the Reduction of the Probability and Magnitude* • ***EV59:*** *(l) Procedure for Accidental or Unintended Radiation Incidents* • ***EV60:*** *(m) Procedure for Non-Medical Imaging Exposures* • ***EV22:*** *(n) Procedure for Dealing with Individuals who Care or Comfort* • ***EV61:*** *(o) Procedure for Radiology Audit* • ***EV62:*** *(p) Procedure for Making Amending and Cancelling any Referrals for an Exposure*		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	MRI Safety Screening All patients complete MRI safety screening prior to scanning this allows the radiology team to identify risks such as implanted devices, metal fragments, or pregnancy preventing serious harm to patients in the MRI environment. Patients using the MRI service are protected from harm through robust safety processes. All patients complete MRI safety screening, including pregnancy checks for those aged 11–55. Where pregnancy is known or suspected, a documented radiologist-led risk–benefit assessment is undertaken, with scans only performed if clinically urgent. In line with MHRA guidance, pregnant patients are scanned in Normal Operating Mode to minimise SAR and noise exposure, with any exceptions fully justified and recorded on the CRIS system. There is also SOP MRI-001 Scanning Claustrophobic Patients within the Department which supports staff in aiding claustrophobic patients and the procedures to follow. • ***EV63:*** *MRI Scanning of pregnant patients* • ***EV17:*** *MR Safety Questionnaire* • ***EV64:*** *SOP MRI-001 Scanning Claustrophobic Patients* **Contrast Media Safety & Anaphylaxis Management** All patients who require Intravenous Contrast for their examination complete contra indications screening prior to their test. This policy covers the contrast administration, eGFR checks, allergy history and emergency management if the need were to arise. The policy protects patients from kidney injury and severe allergic reactions. • ***EV24:*** *SOP104 Chaperones in Radiology* • ***EV65:*** *SOP102 Security and administration of controlled drugs* • ***EV66:*** *SOP101 Safe Custody and administration of medicine and drugs* • ***EV67:*** *SOP 054 WHO checklist* • ***EV68:*** *SOP 015 Extravasation Policy* • ***EV22, EV48-62:*** *Employers Procedures (a-p)* The department also follow other Trust policies (including 30 infections, prevention & control policies) to ensure patients are free from harm: • ***EV69:*** *PD2694-Incident Reporting and Management Policy* • ***EV70:*** *PD2052- Patient Safety Incident Response Policy* • ***EV71:*** *PD0169- Mental Capacity Act and Deprivation of Liberty Safeguards Policy* • ***EV72:*** *PD0302- Safeguarding Adults Policy* • ***EV73:*** *PD0268 Safeguarding Children and Young people* • ***EV74:*** *PD0086-Medicines Policy*		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• ***EV75:*** *PD0387-MWL Chaperone Policy* • ***EV76:*** *PD1622-General Anaesthesia care in the non-theatre environment* **Radiology Governance Meetings / Incident Reporting** All governance and patient safety issues are discussed at the department's monthly Radiology Management meeting. All patient safety incidents and near misses are reported following Trust policies and logged on the Trusts incident reporting system InPhase. All staff within the team report any patient safety incidents or near misses as required. • ***EV77 -*** *Example report and minutes from Radiology Management Meeting*		
1D: Patients (service users) report positive experiences of the service	**MWL Accessibility Survey** The Patient Experience & Inclusion (PEI) Team developed a Patient Satisfaction Survey regarding EDS. Patients were sent surveys during Q3 and Q4 2025/26, the PEI Team would randomly select patients from the service lists and send them a survey to complete. The survey is anonymous and available to complete via QR code, online link and paper (with prepaid envelopes to return). The survey questions are centred around accessibility, looking at access, feeling listened to, receiving information, cultural needs etc. The survey also collects demographics looking at age, sex, ethnicity and disability. There was a total of 500 surveys sent to Radiology patients, with a total of 120 returned (24% response rate). The results of the Radiology survey were positive with all questions positive responses being above 90%. • ***EV1:*** *Radiology EDS Accessibility Survey* **Friends and Family Test** The survey results demonstrate the positive experiences by patients with the Radiology Department overall (all areas) having 92.37% positive recommended care and only 3.05% negative. All themes are positive with no negative themes/feedback. All areas display FFT results monthly in the department and are shared in Operations and Governance Meeting and the Radiology Management Team meeting. • ***EV78:*** *MWL Radiology Friends and Family Test 2025* • ***EV79:*** *Ormskirk Radiology Friends and Family Test 2025* • ***EV80:*** *Southport Radiology Friends and Family Test 2025* • ***EV81:*** *St Helens Radiology Friends and Family Test 2025* • ***EV82:*** *Whiston Radiology Friends and Family Test 2025*	3	MWL Radiology Service

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Radiology Bulletins The team have monthly bulletins that are shared with all Radiology staff regarding feedback on recently received incidents, complaints and compliments received into the Radiology Department across all sites. The bulletins also share information on procedures, systems, infection control and lessons learned etc. – it is important to ensure that all staff continue to review and improve processes to ensure they provide the best possible service to patients that is free from harm. • ***EV40:*** *Example of Radiology Bulletin (1)* • ***EV41:*** *Example of Radiology Bulletin (2)* **Modality focussed Patient Satisfaction Surveys** The department has patient satisfaction surveys designed for the different modalities in the service i.e. CT, MRI, X-Ray. The results from the surveys are very positive and are discussed in the Radiology Management Meetings as well as shared throughout the department on posters. • ***EV83:*** *St Helens Plain Film Patient Questionnaire Results* • ***EV84:*** *Whiston X-Ray OPD Patient Questionnaire Results* • ***EV85:*** *CT Cardiacs Patient Questionnaire Results (Whiston, St Helens)* • ***EV86:*** *CT CDC Patient Questionnaire Results (Whiston, St Helens)* • ***EV87:*** *CT Colon Patient Questionnaire Results (Whiston, St Helens)* • ***EV88:*** *Ormskirk CT Patient Questionnaire Results* • ***EV89:*** *Ormskirk General X-Ray Patient Questionnaire Results* • ***EV90:*** *Southport MRI Patient Questionnaire Results* • ***EV91:*** *Example of CT Patient Satisfaction Survey Poster (Whiston, St Helens)* • ***EV92:*** *Example of CT Patient Satisfaction Survey Poster (Southport and Ormskirk)* • ***EV93:*** *Example of Intervention Patient Satisfaction Survey Poster (Whiston, St Helens)* • ***EV94:*** *Example of MRI Adults Patient Satisfaction Survey Poster (Southport and Ormskirk)* • ***EV95:*** *Example of MRI Children Patient Satisfaction Survey Poster (Whiston, St Helens)* • ***EV96:*** *Example of MRI Radiology Patient Satisfaction Survey Poster (Whiston, St Helens)* • ***EV97:*** *Example of X-Ray Patient Satisfaction Survey Poster (Southport and Ormskirk)* • ***EV98:*** *Example of DEXA Radiology Patient Satisfaction Survey Poster (Whiston, St Helens)* • ***EV99:*** *Example of X-Ray Radiology Patient Satisfaction Survey Poster (St Helens)* • ***EV100:*** *Example of X-Ray Radiology Patient Satisfaction Survey Poster (Whiston)* **Other methods of feedback** You Said Posters are displayed throughout the departments that share comments from patients. Radiology also receives many 'Ask Rob' (CEO) feedback from people who share compliments to the CEO regarding		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	departments within MWL. Feedback from patients who contact the Patient Experience and Inclusion Team is received and the department receive letters and thank you cards directly from patients. • ***EV101:*** *Example You Said Posters displayed within the department* • ***EV102:*** *Example Ask Rob feedback* • ***EV103:*** *Example Feedback through the PEI Team* • ***EV104:*** *Example Feedback received directly into department (Whiston, St Helens)* • ***EV105:*** *Example Feedback received directly into department (Southport and Ormskirk)* All feedback and results are discussed in the department Radiology Management Team meeting; they develop an action plan of positive experiences and any actions/lessons learned that can be developed from feedback. The Radiology Governance Lead and Quality & Accreditation Lead Radiographer are members of the Trust Patient Participation Group, Patient Experience and Inclusion Champions and attend the Patient Experience Council. • ***EV106:*** *Feedback action plan* • ***EV107:*** *Complaints/concerns learning and actions* • ***EV108:*** *You Said We Did* • ***EV77 -*** *Example report and minutes from Radiology Management Meeting*		
Domain 1: Commissioned or provided services overall rating (Radiology Service)		**3**	

2.3.3. Interpreting Service

Outcome	Evidence	Rating	Owner (Dept/Lead)
1A: Patients (service users) have required levels of access to the service	MWL provides interpreters for foreign languages and Deaf patients Foreign languages and translations are provided by DA Language Services (DALS) • Provides face to face, telephone and video interpreting and translation of written information • Also provide BSL for Southport and Ormskirk sites Non-verbal languages and translations are provided by St Helens Deafness Resource Centre for Whiston, St Helens and Newton	2	PEI Team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Provides face to face and video interpreting for BSL, lip readers, Deaf/Blind, note takers and translation of written information into signed video *Noted that interpreting and translation service costs rise year on year and access to face-to-face foreign language interpreters is becoming increasingly difficult across most languages as the pool of interpreters across the who business is reducing.* **Non-verbal interpreters** Patients and service users with disabilities have an electronic alert on their patient record in line with the Accessible Information Standard (AIS) to alert staff they need additional communication support due to their disability, this could be a non-verbal interpreter, or written information in an alternative format including BSL if required. These alerts/markers are put onto the patients record as soon as we are made aware of their needs which can be via the AIS when a patient is asked on their first contact, by a data cleanse that we send out annually via the Deafness Resource Centre, staff there will pass the update forms with a SAE to all their clients to update their details if necessary and we keep their alerts updated as needed, we do get a significant number returned each year from new clients who haven't yet accessed our services or existing clients who need their alert amending. We also have a communication webform that people can complete and tell us what their additional communication needs are. **Foreign language interpreters** Foreign language patients have a marker on their patient record that states their first language and also if an interpreter is required, currently we rely on the patient, family member or advocate to tell us the patients first language is not English and they will require an interpreter **Booking interpreters** For hospital admissions and appointments the admin staff book the interpreter when they are booking the patients appointment onto the system, for appointments this is 6 weeks before the appointment, and for admissions it may be later than that depending on the patients admission date. **Emergency admissions** Obviously cannot be booked in advance so for foreign language patients staff would utilise the telephone or video services.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	For D/deaf patients we would phone the on-call service at the Deafness Resource Centre to get ideally a face-to-face interpreter but if there is no-one available we can use video interpreters until a face-to-face interpreter can attend. *All BSL interpreting at S&O sites is done remotely as those sites use dals as their BSL provider. We make every effort to ensure that a patients are identified so the patients needs are fully met when they access our services. We consider that the provision of interpreting services for patients ensures the patients safety as well as ensuring they can participate in decisions about their own care and treatment. **Translated information** We can translate patient information, letters, results etc into different formats, different languages including BSL on request MWL website is accessible – patients can alter the language on the website and adjust any settings and well as a communication webform where patients can inform us of any communication requirements Foreign language or non-verbal interpreters are used for all patient who need them and translations are provided for patient information on request – both providers have 24/7 services available • Includes pre-booked appointments, inpatient admissions/ emergency admissions cannot be booked in advance, staff utilise telephone and video **Accessible Information Standard (AIS**) – we add alerts on patient records that inform staff if a patient requires additional communication support due to a disability i.e. non-verbal interpreter • Alerts are added onto the patients record as soon as we are made aware of their needs • Work closely with St Helens Deafness Resource Centre – send form via the centre annually to their clients to update their details and records are updated in the Trust Foreign languages are recorded on a patients record under ‘preferred language’ and has a tick box to state an interpreter is required. • The Trust relies on patient referrals and patients/family members/advocates to inform us of the patients first language		

<table>
<tr><th>Outcome</th><th>Evidence</th><th>Rating</th><th>Owner (Dept/Lead)</th></tr>
<tr><td></td><td>
MWL Accessibility Assessments – review communication methods/support for patients across the Trust

EDS Accessibility Survey – 93% of patients felt they could access the service when they needed to

Access:

• 264 Deaf patients seen across MWL sites in 2025
• 10,094 foreign language patients seen across MWL sites in 2025

<table>
<tr><th></th><th>Deaf patients</th><th>Foreign language patients</th></tr>
<tr><td>Outpatients</td><td>153</td><td>5442</td></tr>
<tr><td>Inpatients</td><td>58</td><td>1374</td></tr>
<tr><td>Emergency Dept.</td><td>53</td><td>3278</td></tr>
</table>
• Foreign language interpreters (activity)
  ◦ Face to face n=9,115
  ◦ Telephone =3,832
  ◦ Video n=91
• Non-verbal interpreters (activity) Whiston, St Helens, Newton sites
  ◦ Face to face n=429
  ◦ Video n=27
• All fill rates were above 90%
  ◦ STHK sites foreign language = 91%
  ◦ S&O sites foreign language = 92%
  ◦ BSL (STHK sites only) = 99%

Gaps identified with patients being able to contact the Trust using the interpreting services which is currently being explored in the Trust

Accessibility Survey
Surveys were sent to patients who had used the interpreting services provided by the Trust in Q3 of 2025/26 in the patients first language, so 50 surveys were sent in each of the most used foreign languages and BSL:

• BSL
</td><td></td><td></td></tr>
</table>

<table>
<tr><th>Outcome</th><th>Evidence</th><th>Rating</th><th>Owner (Dept/Lead)</th></tr>
<tr><td></td><td>

Arabic
Portuguese
Polish
Romanian
Traditional Chinese

A paper copy of each survey was sent out with a return envelope and covering letter, and also included a link so the survey could be completed online if preferred

Of the 300 surveys sent out only 15 were returned, 14 paper copies and one online which gave a response rate of only 5%, which was disappointing.

*every patient who were sent a survey had consented to receive communications from the Trust.

Demographics

Sex
<table>
<tr><th></th><th>Total</th><th>%</th></tr>
<tr><td>Male</td><td>6</td><td>40.0%</td></tr>
<tr><td>Female</td><td>9</td><td>60.0%</td></tr>
<tr><td>Self-define</td><td>0</td><td>0.0%</td></tr>
</table>
The sex of the respondents shows the percentage of female respondents is higher than the percentage of females in the communities we serve where the percentage of females is only very slightly higher than males.

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Age
<table>
<tr><th></th><th>Total</th><th>%</th></tr>
<tr><td>0-15 years</td><td>0</td><td>0.0%</td></tr>
</table>
</td><td></td><td></td></tr>
</table>

<table>
<tr><th>Outcome</th><th>Evidence</th><th>Rating</th><th>Owner (Dept/Lead)</th></tr>
<tr><td></td><td>
<table>
<tr><td>16-24 years</td><td>0</td><td>0.0%</td></tr>
<tr><td>25-34 years</td><td>1</td><td>6.7%</td></tr>
<tr><td>35-44 years</td><td>0</td><td>0.0%</td></tr>
<tr><td>45-54 years</td><td>3</td><td>20.0%</td></tr>
<tr><td>55-64 years</td><td>4</td><td>26.7%</td></tr>
<tr><td>65-74 years</td><td>2</td><td>13.3%</td></tr>
<tr><td>75-84 years</td><td>1</td><td>6.7%</td></tr>
<tr><td>85+ years</td><td>1</td><td>6.7%</td></tr>
<tr><td>Prefer not to say</td><td>3</td><td>20.0%</td></tr>
</table>

The highest number of patients accessing our services is 76-84 years, but one of the lowest response rates. Maternity services are a big user of interpreting services so I was disappointed we had no responses from women who had used maternity. I also sent surveys out to the parents of children for their feedback but didn’t receive any responses i.e. parent needed an interpreter

Ethnicity
<table>
<tr><th></th><th>Total</th><th>%</th></tr>
<tr><td>White</td><td>11</td><td>73.3%</td></tr>
<tr><td>Mixed / Multiple Ethnic Groups</td><td>0</td><td>0.0%</td></tr>
<tr><td>Asian / Asian British</td><td>3</td><td>20.0%</td></tr>
<tr><td>Black / African / Caribbean / Black British</td><td>1</td><td>6.7%</td></tr>
<tr><td>Other ethnic group</td><td>0</td><td>0.0%</td></tr>
</table>

Disability
5/15 respondents disclosed they had a disability (33%)
• 1 patient have a physical disability
• 4 patients have a sensory disability
</td><td></td><td></td></tr>
<tr><td>1B: Individual patients (service</td><td>• Provide interpreters at any stage of the patient journey
• Also provide for parents/carers if needed
• Enables full participation in own health care
• Make informed choices/decisions
• Assurance that patient has been given information in the way they can best understand</td><td>2</td><td>PEI Team</td></tr>
</table>

Outcome	Evidence	Rating	Owner (Dept/Lead)
users) health needs are met	• Consent – patient knows what they are consenting to (assurance for clinician) • Ability to block book interpreters for e.g. maternity or cancer services – cover lots of appointments – can book same interpreter to assist patient throughout • Communication boxes – available across all patient areas in the Trust and have information regarding interpreting services and communication aids • **Examples** – Maternity patient with two BSL interpreters / Deaf maternity patient with concerns about going home / Refugee mums support from interpreter • **EDS Accessibility Survey** - over 90% of patients felt they were listened to, received enough information, questions answered in a way they could understand, and cultural/social needs were met • **MWL Accessibility Assessments** – review communication methods/support for patients across the Trust and working to address any issues/barriers found **Gaps identified in the use of video interpreting and technology to do so across the Trust** **Non-verbal interpreters** Patients and service users with disabilities have an electronic alert on their patient record in line with the Accessible Information Standard (AIS) to alert staff they need additional communication support due to their disability, this could be a non-verbal interpreter, or written information in an alternative format including BSL if required. These alerts/markers are put onto the patients record as soon as we are made aware of their needs which can be via the AIS when a patient is asked on their first contact, by a data cleanse that we send out annually via the Deafness Resource Centre, staff there will pass the update forms with a SAE to all their clients to update their details if necessary and we keep their alerts updated as needed, we do get a significant number returned each year from new clients who haven't yet accessed our services or existing clients who need their alert amending. We also have a communication webform that people can complete and tell us what their additional communication needs are. **Foreign language interpreters** Foreign language patients have a marker on their patient record that states their first language and also if an interpreter is required, currently we rely on the patient, family member or advocate to tell us the patients first language is not English and they will require an interpreter **Booking interpreters** For hospital admissions and appointments the admin staff book the interpreter when they are booking the patients appointment onto the system, for appointments this is 6 weeks before the		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	appointment, and for admissions it may be later than that depending on the patients admission date. **Emergency admissions** In an emergency interpreters cannot be booked in advance so for foreign language patients staff would utilise the telephone or video services. For D/deaf patients we would phone the on-call service at the Deafness Resource Centre to get ideally a face-to-face interpreter but if there is no-one available we can use video interpreters until a face-to-face interpreter can attend. *All BSL interpreting at S&O sites is done remotely as those sites use dals as their BSL provider. We make every effort to ensure that a patients requirements are identified and up to date so the patients needs are fully met when they access our services. We consider that the provision of interpreting services for patients ensures the patients safety as well as ensuring they can participate in decisions about their own care and treatment. **Translated information** We can translate patient information, letters, results etc into different formats, different languages including BSL on request MWL website is accessible – patients can alter the language on the website and adjust any settings and well as a communication webform where patients can inform us of any communication requirements		
1C: When patients (service users) use the service, they are free from harm	All foreign language interpreters are DBS checked and are eligible to work in the UK and are all fully qualified to interpret in a healthcare environment, with a variety of qualifications and experience for foreign language interpreters. Their language skills are regularly tested by the provider as part of interpreters annual appraisal and in all instances if we raise a complaint if the patient was not happy with the quality of the interpretation,. BSL interpreters are also DRB checked and must be qualified to level 6 or above in order to interpret in a health care setting.	3	PEI Team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Interpreters are given mandatory safeguarding training by the provider which is updated every year, and must also sign a contract that contains a confidentiality clause in it and any breaches would lead to instant dismissal. MWLs Head of Patient Inclusion and Experience led on the development of a set of quality standards for interpreting services on behalf of all Trusts in Cheshire and Merseyside, these standards are embedded into all C&M provider contracts as the minimum standard/qualifications of interpreters that will be accepted to work in the Trusts with patients. Our policy states that family members, friends and members of staff cannot interpret unless in an emergency situation until a qualifies interpreter is available, but they can only interpret patient details but not clinical information, and this has to be documented in the patients notes as the Trust cannot accept responsibility for any interpretation or translation unless carried out by a qualified, contracted interpreter. (Ref 1) Wherever possible we will secure an interpreter of the patients preferred sex, this is usually possible unless it a very rare language, in which case we will try to secure the required interpreter by video or telephone if appropriate. By using an external independent provider of interpreting services with the condition that foreign language interpreters do not interpret for any person(s) that they know we can ensure the patient/service users health history remains confidential. D/deaf patients often have interpreters they work with regularly, so if possible we try to secure the interpreter they are used to/work best with to ensure the patient gets the best out of any interpretations carried out. We also ensure that children whose parents first language is not English are provided with an interpreter so that the parent can be fully aware of any diagnosis and the care and treatment their child will need moving forward including any care the parents need to provide at home, and also it is very important that children are not used to interpret information to their parents/carers in any situation. This is especially important if a child attends with a parent and is asked to interpret for many reasons. The child could be traumatised by what they are asked to interpret, the parent may not want the child to know why they are at the hospital and children cannot be expected to have the language skills to describe/interpret clinical information so should never be used in this way. (Ref 1)		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Interpreter incidents are reported through the Trust InPhase system following Trust policy – incidents reported in 2025 relate to difficulties obtaining an interpreter • Estates and equipment in good repair (regular scheduled checks), fixed window openings • Culturally aware staff, with support from EDI teams if needed • Carers passport, carers allowed to stay with vulnerable patients overnight and participate in their care • EDS Accessibility Survey - over 90% of patients felt they were listened to, received enough information, questions answered in a way they could understand, and cultural/social needs were met • Training – PEI Team provide training regarding interpreters/processes and St Helens Deafness Resource Centre provide Deaf Awareness Training routinely across the Trust for all staff		
1D: Patients (service users) report positive experiences of the service	• EDS Accessibility Survey - over 90% of patients felt they were listened to, received enough information, questions answered in a way they could understand, and cultural/social needs were met • DALS – MWL staff provide feedback to the company regarding the interpreter's performance • PEI Team – adhocly send patient surveys to foreign language patients regarding the interpreting service they received • PEI Team work very closely with St Helens Deafness Resource Centre. • Positive and negative feedback regarding interpreters is acted upon – any concerns/issues are developed into action plans which are reported and monitored formally – *example DRC action plan with executive overview*	3	PEI Team
Domain 1: Commissioned or provided services overall rating (Interpreting Service)		**2**	

Independent Evaluator(s)/Peer Reviewer(s): Domain 1

Representatives and managers from the following Healthwatch organisations Healthwatch Sefton, Healthwatch Knowsley, Healthwatch Lancashire, and Cheshire and Merseyside ICB, and senior Trust staff including Chief Nurse, Deputy Chief Nurse and Deputy Director of Governance, Quality and Patient Experience

2.4. Domain 2: Workforce health and well-being

Outcome	Evidence	Rating	Owner (Dept/Lead)
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	1. **The organisation monitors the health of all staff:** The Trust maintains a dedicated Health Work and Wellbeing (HWWB) team that monitors the overall population health of the workforce and implements targeted strategies to support staff and improve sickness absence metrics. HWWB provide Pre-Employment checks for all applicants, including fitness to practice assessments, and discussions about any workplace disability adjustments; offers a management and self-referral service for ill-health, mental health, counselling, disability, and sickness absence support; Health Surveillance health checks including noise exposure, ionising radiation, solvents, dust, and biological agents; a dedicated Wellbeing Hub offering physical and non-physical health matters (including suicide prevention, mental health first aid, menopause support, stress risk assessments, and general wellbeing). Policies include the Disability Reasonable Adjustment Passport, and Stress Risk Assessments. 2. **The organisation supports all staff to actively manage their conditions via various methods**: The HWWB website includes extensive self-help advice relating to smoking, alcohol, substance misuse, psychological wellbeing, trauma, exercise and weight management, and nutrition (Health Inequalities). Occupational Health provides support for staff including recommendations and workplace support advice including disability, stress, and mental wellbeing. The Wellbeing Team include dedicated Psychologist, a Mental Health Nurse, and a Counsellor. The Trust offers an Employee Assistance Programme which provide a suite of self-help resources as well as online/virtual support. The Wellbeing Hub runs an extensive programme of events across the Trust and virtually each year. This includes events on Psychological Safety, Suicide Prevention, Disability Reasonable Adjustments, and Menopause. 3. **How the organisation uses sickness and absence data to support staff to self-manage long term conditions and to reduce negative impacts of the working environment**: The Trust has a dedicated Absence Management Team (HR) which provides support for Line Managers and Employees to manager sickness absence, welfare conversations, and a successful return to work. Processes are in place for the absence management team to flag to	2	Health, Work & Wellbeing

Outcome	Evidence	Rating	Owner (Dept/Lead)
	HWWB incidents where a member of staff has been off for stress or MSK reasons to trigger additional support. Where an employee is returning to work, they may be offered a return-to-work plan, and where the reason for the absence was because of a disability, and workplace reasonable adjustments conversation. Weekly comprehensive sickness and absence reports are generated and reviewed by the HR Senior Leadership Team, with more detailed reports provided at the department level to enable managers to make informed decisions aligned with the Attendance Management Policy. Detailed EDI analysis using this data is not currently used to target interventions, although staff survey data (my manager takes a positive interest in my health and wellbeing) is analysed by EDI categories to inform actions. 4. **The organisation actively works to increase health literacy within its workforce**: To enhance the workforce's health literacy, the HWWB team, supported by 257 wellbeing champions and 96 mental health first aiders, maintains informational boards, and organises regular departmental drop-in sessions/events, including an annual event to foster health awareness, which includes information about diabetes, respiratory diseases, dermatology, and sexual health, mental health, smoking cessation, and addiction. An annual program of wellbeing events is provided (mindfulness, De-Stress, menopause, neurodiversity, nutrition), as well on a suite on online self-help materials (sleep, alcohol, substance misuse, long term health conditions); and (new) eLearning materials are available (via Personal Development Portal), on topics including Menopause, Neurodiversity, Mental Health, and healthy living). Dedicated awareness weeks are held each year including MWL Summer Wellbeing Week and Stress Awareness Week. 5. **How the organisation promotes and provides innovative initiatives for work-life balance, healthy lifestyles, encourages and provides opportunity to exercise**: The Trust has a suite of family friendly (adoption, maternity, paternity, shared parental, parental, carers, baby loss) and flexible working policies and has worked to promote flexible working options. This year HR ran a dedicated Flexible Working promotional campaign targeting division management teams and staff. The Trust has introduced innovative initiatives like the 'Find Your Fit' 12-week programme, chair yoga sessions, and the menopause café, which have been widely		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	embraced by the staff. The Trust has 257 wellbeing champions and 96 Mental Health First Aiders to promote wellbeing initiatives. The Trust is now able to deliver Mental Health First Aid Training inhouse and is successfully expanding this offer to staff. The Personal Development Portal includes resources on; Paternity Leave, Work-Life Balance, Flexible Working, Children & Work, Homeworking H&S; and Healthy Living, Healthy Habits. However, the staff survey (My organisation takes positive action on health and well-being) shows differences in staff members experience based on EDI categories. 6. **The organisation signposts to national and VSCE support**: The HWWB team has a comprehensive intranet site that directs staff to various national and voluntary support networks. These resources are actively promoted by Wellbeing Champions and through Team Briefs, ensuring widespread accessibility and support for the Trust's workforce. The Anti-Racism, LGBT+, Trans, Carers, Sexual Safety,, Harassment, and Disability Hubs provide comprehensive sign posting to local, regional and professional support groups. 7. **The organisation uses data to support their workforce in making healthy lifestyle choices**: HWWB data has not been routinely analysed by EDI categories. User data is used to inform the development of services and prioritise of the HWWB service., for example targeted activities for employees and line managers where a referral has not been attended. Staff are not explicitly targeted for interventions based on data. Data is not routinely analysed for this purpose. 8. **The organisation monitors the health of staff with protected characteristics**: The Trust does not currently actively monitor or report the health of staff by equality categorise. No reports have been provided in 2025 with disaggregated data. 9. **The organisation targets reading materials about managing obesity, diabetes, asthma, COPD, and mental health conditions to staff**: A suite of online materials are available via the self-help portal and the personal development portal; a calendar of wellbeing events, wellbeing information stalls, HWWB drop-in sessions, and regular communications/sign posting to all members of staff. Topics include healthy living and exercise, and mental health. Materials are not directly target at specific staff groups / staff with specific conditions outside HWWB/OH support.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	1. **The organisation has and actively implements a zero-tolerance policy for verbal and physical abuse towards staff**: The Trust is dedicated to maintaining a safe and respectful work environment, upheld by its suite of policies targeting unacceptable behaviour, bullying and harassment, domestic abuse, and safeguarding. The Trust has 15+ policies relating to abuse, including Respect & Dignity at Work (our anti-bullying and harassment policy), Domestic Abuse, Managing Unacceptable Incidents from Patients, Safeguarding, and Lone Worker polices. Our zero-tolerance stance is regularly reaffirmed by the Chief Executive via News Articles / CEO Blog / email. Zero Tolerance Posters are available across the Trust estate as well as posters relating to Sexual Harassment, Sexual Safety, the Signs of Domestic Abuse, and Body Cameras in Use. Key information and strategies like the Violence Reduction Strategy and use of bodycams are disseminated through the Trust's intranet, with additional security measures enforced through collaboration with local police and designated safety roles. Training is available to staff on Bullying & Harassment, Sexual Harassment & Sexual Safety, Conflict Resolution, Safe Lone Working, Domestic Violence, and Violence Reduction. This year the Trust has marked various dates which promote inclusive behaviours, including LGBT History Month, Black History Month, Disability History Month, and Anti-Bullying Week. On the website we maintain and regularly update hubs on Harassment, and Sexual Misconduct. Through our relationship with Merseyside Police, we actively work to support staff to report violence, abuse and Hate Crimes to the police, support their investigations as much as possible. In 2025, the Trust adopted a new MWL Anti-Racism statement specifically emphasising our commitment to challenging racism in all its forms. 2. **The organisation penalises staff who abuse, harass or bully other members of staff**: The Disciplinary Policy and Respect and Dignity at Work Policy strictly prohibit bullying, harassment, and violence, detailing consequences for such misconduct. These aim to establish a clear understanding among staff of acceptable behaviour and provide a structured approach to handle complaints. The Staff Disciplinary policy explicitly lists violent, dangerous, intimidatory conduct; bullying or exceptionally offensive behaviour; discrimination, victimisation or harassment; and any Criminal	2	Human Resources, Security, Safeguarding

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Offence (Hate Crimes, Sexual Assault, Assault) as forms of Gross Misconduct, which may lead to dismissal. 3. **The organisation takes action to address and prevent bullying behaviour and closed cultures, recognising the link between staff and patient experience:** a. **Policies**: as outlined above b. **Training**: Extensive training is available inhouse, and online including Harassment for Line Mangers, Sexual Harassment & Sexual Safety, Domestic Abuse, Difficult Conversations, Awareness courses on LGB / Trans / Race equality, Cultural Competency; and Active Bystander training has also been introduced this year. Online courses include good management practice topics, cultural competency, and management and leadership skills. c. **Advice and Guidance**: Staff who experience bullying and harassment can seek advice and support from their Line Manager, Trade Union, HRBP's, EDI, and Freedom to Speak Up Guardians. FTSU offers a online reporting form (including anonymously), and InPhase is actively used to report B&H and violence involving patients. d. **Bullying by Patients et al:** Staff are supported in reporting and managing abusive incidents from patients, defined under the policy addressing unacceptable behaviour. This includes a range of actions deemed harmful or disruptive, particularly towards staff with protected characteristics. The Trust's response includes clear procedures for dealing with such behaviour, emphasising a secure working environment, with the ultimate sanction of removal from the hospital. e. **Events**: In promoting inclusive behaviours. the Trust has a dedicated Sexual Safety Pledge (now signed by over 470 staff), and a Anti-Racism Pledge (signed by over 400 staff) and LGBT Inclusion Pledge (signed by 100 staff). Engagement activities have included information stalls, Wear Red Day, and events including Anti-Bullying Week, Pride Month, and Trans Awareness. 4. **Staff with protected characteristics are supported to report and refuse treatment to patients who verbally or physically abuse them**: Staff are supported in reporting and managing abusive		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	incidents from patients, defined under the policy addressing unacceptable behaviour. This includes a range of actions deemed harmful or disruptive, particularly towards staff with protected characteristics. The Trust's response includes clear procedures for dealing with such behaviour, emphasising a secure working environment, with the ultimate sanction of removal from the hospital. Staff can also seek advice and support from their Line Manager, Trade Union, HRBP's, EDI, and Freedom to Speak Up Guardians. The Trust is a member of Operation Cavell, and agreement with Merseyside Police to ensure incidents of violence and abuse are addressed promptly. Incidents this year have led to a number of arrests and prison sentences. The Trust provides extensive web resources including a Harassment Hub, and a Security Hub to promote reporting options. The Harassment Hub includes specific guidance on topics including Domestic Abuse, Sexual Harassment, Hate Crimes, and Honour Abuse. 5. **The organisation provides appropriate support to staff and where appropriate works with VSCE organisations to provide support for those with protected characteristics who have suffered verbal and physical abuse:** Support is available to staff to make a complaint via HR, Trade Unions, Freedom to Speak Up, and EDI. Where required HR/Line Managers can arrange workplace support during investigations or after care, and may include conflict resolutions (mediation), training or other interventions. The Trust signposts to Disability, Ethnicity, LGBT+, Trans, Domestic Violence community groups and hate crime (including religious based) reporting services via website Hubs, and Trust Security are available to respond to violent incidents. HWWB services are available such as counselling and wellbeing to assist staff impacted by incidents. 6. **The organisations can provide evidence that percentages for bullying and harassment are decreasing year on year for any staff group were there are higher than average incidents**: According to the staff survey, reported incidents violence and harassment increased between 2024 to 2025, although with an overall drop compare to 2022, and reported incidents are lower than the NHS averages. When comparing outcomes for equality groups the staff survey results do show differing levels of physical violence and or harassment in some cases.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	a. **Harassment From Service Users**: In 2025, 5 EDI categories where higher than the MWL average. b. **Harassment from Managers:** In 2025, 7 EDI categories where higher than MWL average. c. **Harassment from Colleagues:** In 2025, 6 EDI categories where higher than the MWL average. 7. **Staff Survey Response:** The staff survey results are used by all departments to identify key areas of improvement and take steps to address them. L&OD manage the dissemination of the results and coordinate the collation of a Trust action plan, which includes responses to the B&H questions. Examples of actions taken directly from the staff survey include introduction of Active Bystander Training. 8. **The organisations use evidence from people's experiences to inform action, change, and influence other system partners to do so**: The Trust works with multiple partners including the Universities, Councils, ICB's, other Trust and NHSE amongst others sharing insights and supporting developments, initiatives and policies. Examples include contributing to the development of the Rainbow Charter framework and the NW Anti-Racism Charter process.		
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	1. **The organisation supports union representatives to be independent and impartial:** The Trust recognises and provides 'facilities time' to the following unions, Unison, RCN, RCM, British Dietetic Association (BDA), British Association of Occupational Therapists, CSP, BIOS, BMA, Society of Radiographers, Unite the Union. Union representatives carry out their duties during work time, and are members of numerous Trust committees including the People Performance Council, Valuing our People Council, JNCC, and Policy Sub Group. 2. **The organisation facilitates pooling of union representatives with partner organisations**. MWL does facilitate the pooling of union representatives where there is a need / benefit to do so for example with the RCN reps who will support nurses across the region- in other Trusts. 3. **Freedom to Speak Up Guardians are embedded and empowered.** The Trust has 4 Freedom to Speak up Guardians offering staff a confidential way to raise concerns about any aspect of their work or environment, including abuse or harassment. In	3	Human Resources

Outcome	Evidence	Rating	Owner (Dept/Lead)
	addition, a network of 40+ Freedom to Speak Up Champions exist who act as ambassadors for the trusts raising concerns/FTSU work. They work within teams to provide accessibility and familiarity. Anyone can apply to be a champion, but the trust aims to ensure there is representation across the organisation. 4. **Relevant staff networks are staff led, funded, and provided protected time to support and guide staff who have suffered abuse, harassment, bullying and physical violence from any source.:** The Trust supports 7 staff-led networks, each focusing on different aspects of staff identity and experience. These networks provide peer support and sign posting for those experiencing stress, abuse, bullying harassment, and physical violence and advocate for specific needs related to staff from the following communities LGBTQIA+, Armed Forces, BAME, Disability, Carers, Menopause,, and Women's Network. Staff Networks are supported by the EDI Team (HR) who provide advice, admin/events/media support, funding, and consultation/engagement activities, including Equality Impact Assessments. 5. **Relevant staff networks are engaged, and equality impact assessments are applied when amending or creating policy and procedures for reporting abuse, harassment, bullying and physical violence:** Network chairs are members of the Equality Steering Group, the principal committee responsible for the development and oversight of the Trust EDI Plan, policies, action plans and priorities. In addition, Network Chairs have regular meetings with the EDI Team through which they can put forward ideas and improvements and raise any concerns. Networks are engaged, where relevant, on policy, action plan, charter mark, and accreditation processes. Networks are free to engage in all consultations added to the trust's consultation portal. Examples have included consultation on the Staff Trans Support Policy, and our Anti-Racism Statement. This year a special Staff Network Team talk was held which led directly to a review of Staff Network support being identified as a priority project by the CEO. However, currently 5/7 networks do not have a chair and are being run by the EDI Team limiting self-directed activities. 6. **Support is provided for staff outside of their line management structure:** Staff can access information, advice and support from the following:		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	○ The HR Operations Team - Policies, procedures, terms and conditions, workplace concerns. ○ The Workforce EDI Team - Reasonable adjustments, concerns regarding bullying or discrimination ○ Health Work & Wellbeing - The wellbeing hub, psychological services, occupational health, employee assistance programme (EAP), wellbeing champions, mental health first aiders (MHFAs) ○ The Freedom to Speak Up Guardian and Champions. ○ Trade Unions. ○ Security Staff (Estates & Facilities) and Police - assaults, hate crimes ○ Staff Networks - peer support, sign posting 7. **The organisation monitors, and acts upon, data surrounding staff abuse, harassment, bullying and physical violence.** The Trust monitors data from employee relations cases, freedom to speak up, security, and safeguarding in relation to abuse and harassment. The staff survey questions on physical violence, harassment and sexual harassment are thoroughly analysed to identify trends and areas of concern. Harassment data is also reviewed as part of the annual WRES, WDES, and EDS self-assessments and where relevant actions are identified. A comprehensive staff survey review and action planning process takes place each year, where departments are required to review and act on their results, and actions included within the HR People Plan and action plans (EDI embedded throughout) are reviewed/updated to take account of any changes in priorities. Actions relating to physical violence, harassment, and sexual harassment are incorporated into actions for the EDI Team, Security, L&OD, HR, and department action plans were relevant, as identified by the analysis. 8. **The organisations use evidence from people's experiences to inform action and change and influence other system partners to do so**: The People Performance/Valuing Our People/Strategic People Councils receive regular reports on HR and People processes including employee relations cases, HWWB User Statistics, Staff Survey Results, EDI Population Trends, WRES/WDES/EDS assessments, Freedom to Speak Up, Security/Incidents, Safeguarding, and Staff Stories. This intelligence		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	is used to inform and agree actions to address negative trends and concerns, and to monitor the implementation of actions.		
2D: Staff recommend the organisation as a place to work and receive treatment	1. **% of staff who live locally to services provided by the organisation do/would choose to use those services.**: This is not an explicit question in the staff survey. Staff at MWL are more likely than the NHS/Comparator average to agree that in the organisation 1) patients are our top priority, 2) it acts on patient concerns, and 3) I would recommend the Trust to friends/relatives for care. 2. **% of staff who live locally are happy and regularly recommend the organisation as a place to work.:** 50-69.9% of staff would recommend the Trust as a place to work. 3. **% of staff who live locally to services provided by the organisation would recommend them to family and friends:** 50-69.9% of staff state that they would recommend the trust to friends/family for care. 4. **The organisation uses sickness and absence data to retain staff, with a staff retention plan in place:** Sickness absence is monitored by line managers, with the support of the dedicated Absence Management Team. The process requires regular wellbeing meeting to take place to support the employee and facilitate a supportive return to work. The Trust can support staff via a number of policies including employment breaks for long-term health or personal issues, flexible working, workplace reasonable adjustments, stress risk assessments, and return to work plans. The HWWB resources, including support from Occupational Health, is available to assist staff with health issues, facilitating an earlier return to work and retention in work. More broadly sickness absence data is monitored at department and Trust level with action taken where data/trends identify potential issues. 5. **The organisation uses data from end of employment exit interviews to make improvements**: The Trust has introduced a new exit interview process which is improving the quality of data captured, which is then shared with HRBP teams. The survey does capture EDI data on a opt in basis. 6. **The organisation collates and compares the experiences of BAME, LGBT+ and Disabled staff against other staff members, and acts upon the data.**: the Staff Survey results are extensively analysed across data sets by Age, Disability, Ethnicity (White v	2	Human Resources

Outcome	Evidence	Rating	Owner (Dept/Lead)
	BAME); 4 Ways (White, Asian, Black, Other), 18 Ways (All ethnic categories), Sex, Sexual Orientation, Religion; and where relevant cross references by Staff Group, Department and Intersectional Data by the EDI Team. Actions are identified from the data and incorporated into relevant operational plans e.g. the annual EDI team prioritises, or department staff survey actions. 7. **The organisation works with partner organisations to better the experiences of all staff**: The organisation works with a number of partner organisations to improve the experience of all staff in line with the broader NHS People Plan. The organisations include 3rd party companies, membership organisations, charities and VSCE's. Examples include Employee Assistance Programme, Rugby League Cares, Access to Work, Veterans Covenant Healthcare Alliance, Disability Confident, via Job Centre Plus, NHS Employers, Local Authorities. The Trust works with regional and national NHS networks including the ICB and NHS NW and NHS England.		
Domain 2: Workforce health and well-being overall rating		2	

2.5. Domain 3: Inclusive leadership

Outcome	Evidence	Rating	Owner (Dept/Lead)
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	1. **Both equality and health inequalities are standing agenda items in all board and committee meetings.:** EDI and Health Inequality agenda items are regularly discussed at the Trust patient and workforce governance committees and the following reports are standing items in the annual committee business • Pay Gap (Disability, Ethnicity, Gender, Sexuality); Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); ; Sexual Safety Charter implementation. • Patient EDI & Inclusion Reports; Freedom to Speak Up; Safeguarding; Violence Reduction Strategy. • Service updates on Maternity. Children, Young People, Women's & Children's Health, Primary Care, Learning Disability & Mental Health, Chaplaincy etc. 2. **Board members and senior leaders meet frequently with staff networks.:** Staff EDI Networks are provided with strategic support by a dedicated Workforce EDI Team. Network chairs meet formally with the Network Coordinator who escalates agenda items through the EDI Team to HR management were relevant. Network chairs are members of the Trust EDI Steering Group having direct access to EDI decision makers including Senior HR leaders, Patient Governance and Trust Executive members. The Trust has an EDI Senior Champion on the Trust Executive Team who meets with chairs periodically and attends network meetings on request. A special Staff Network team talk event was organised this year were network representatives had the opportunity to feed back to a number of exec members. 3. **Staff networks have more than one senior sponsor**: Network sponsors are the Medical Director/Senior EDI Champion (all networks), Chief Executive (Anti-Racism Champion/BAME Network), Director of Strategy (Women's Network), and Chief Operating Officer (Menopause Network). 4. **Board members and senior leaders sponsor religious, cultural or local events and/or celebrations.:** Trust Executive Team members engage in a series of EDI related activities each year including sponsoring cultural, religious and other EDI events, campaigns and celebrations. Activities include demonstrating the Trusts commitment to EDI via News Articles (e.g. Trust Values,	2	Human Resources Patient Inclusion & Experience Governance Team Board/Trust Exec

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Diwali), introducing / presentation topics in Trust Brief Live (e.g. LGBTHM, BlackHM etc), attendance and speaking at events (Diwali, Anti-Racism Launch events, Easter and Christmas services etc), and participating in EDI allyship (signing the MWL Anti-Racism Pledge) etc. 5. **Board members and senior leaders enable underserved voices to be heard.** Senior Leaders enable "underserved voices" to be heard through a number of forums. Staff Stories and Patient Stories are regular features at on Trust committee agendas. Patient stories have included topics ranging from end of life care, cancer treatment, and patient wellbeing. Staff stories have included the experience of staff in Lead Employer.. Senior leaders promote EDI opportunities (staff networks, events, campaigns) through Trust Brief Live and regular all trust communications. The EDI Team have been invited to do "Team Takeovers" at Trust Brief Live on topics including Anti-Racism and Carers Week. The Trust further supports Staff Networks: BAME, Disabled, Carers, LGBTQIA+, Menopause, Women's and Veterans who work to raise the voices of their members. 6. **Board members hold services to account, allocate resources, and raise issues relating to equality and health inequalities on a regular basis.** The Board receive and scrutinise all the EDI reports, as well as performance reports relating to workforce and operations; quality reports from the Trust Committees, and key annual reports including Trust strategy updates and annual reports on topics such as safeguarding, Health Work & Wellbeing and EDI. 7. **Board members implement the Leadership Framework for Health Inequalities Improvement.** The Trust has not implemented this framework to date. 8. **Board members and senior leaders demonstrate commitment to health inequalities, equality, diversity and/or inclusion**: Each member of the Trust Executive Team has engaged with the EDI/Health Inequalities agenda. This has included reviewing the following: • Trusts WRES, WDES, Statutory Pay Gap, and Staff Survey results. • Board Anti-Racism away day, and adoption of the MWL Anti-Racism Statement. • attendance at cultural events including Diwali; and championing EDI within their areas of responsibility.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• The Chief Executive is the named Anti-Racism Champion; the Deputy Chief Executive the Domestic abuse and sexual violence (DASV) lead; the Medical Director is the Senior EDI Champion; and the Director of Integration is the Health Inequalities lead. 9. **Board members and senior leaders actively communicate with staff and/or system partners about health inequalities, equality, diversity and inclusion.**: The Trust Executive Team communicates extensively on EDI/Health Inequalities through the Trust Brief Live, Trust News articles (external news, and internal staff news), CEO Blog, MWL News (Email), and attendance at EDI events. Topics have included: Racial Harassment Zero Tolerance, Sexual Assault/Violence, Sexual Safety Charter, Flexible Working, Stress Awareness Week, World Suicide Prevention Day, Liverpool Pride, Accessible Documents, Baby Loss Awareness, Flexible Working, FTSU, Black History Month, and World AIDS Day.		
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	1. **Both equality and health inequalities are standing agenda items in all board and committee meetings.:** EDI and Health Inequality agenda items are regularly discussed at the Trust patient and workforce governance committees and the following reports are standing items in the annual committee business • Pay Gap (Disability, Ethnicity, Gender, Sexuality); Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); EDI Operational Plan Update; Sexual Safety Charter implementation. • Patient EDI & Inclusion Reports; Freedom to Speak Up; Safeguarding; Violence Reduction Strategy. • Service updates on Maternity. Children, Young People, Women's & Children's Health, Primary Care, Learning Disability & Mental Health, Chaplaincy, etc. 2. **Equality and health inequalities impact assessments are completed for all projects and policies and are signed off at the appropriate level where required.:** The Trust has a robust Equality Impact Assessment (EIA) toolkit including a Standard Operating Procedure, Screen and Full Assessment templates. The form includes section to assess EDI, Health Inequalities, and Human Rights. A dedicated web resource is available, and training is available to staff throughout the year. The Trust EIA process states that the Screening Form must be completed in the following	2	Human Resources Patient Inclusion & Experience Governance Team Board/Trust Exec

Outcome	Evidence	Rating	Owner (Dept/Lead)
	situations, unless a Full Impact Assessment has been completed first: • When developing new policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects • When reviewing the implementation of policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects A full EIA is required in the following situations: • Planning of cost improvement programmes • Introducing new services • Moving existing services to a new/different site • Planning of new healthcare or employment services • Decommissioning of existing healthcare or employment service • During organisational change processes • Redundancy situations The screening form is embedded in the Trust policy template as part of the approval/assurance process which all policies must have completed. The depth/quality of assessments is an ongoing issue. 3. **Staff risk assessments, specific to those with protected characteristics, are completed and monitored (where relevant).**: The Trust's Health, Work and Wellbeing department provides Occupational Health, Health Surveillance, Infection Prevention and Control, Non-Clinical Risk, and Wellbeing services to all members of staff. These services include all forms of health-based risk assessments and relevant support plans to address risk or support staff in the workplace. Where relevant topic specific risk assessment are completed by the relevant department such as Personal Emergency Evacuation Plans, Pregnancy & Maternity Risk Assessments, Lone Working Assessments, and Stress Risk Assessments. The Trust has an extensive policy framework to manage and mitigate risk including Lone Workers, Violence Reduction, Stress Risk Assessment, and Menopause. 4. **Required actions and interventions are measured and monitored. The WRES, WDES and/or NHS Oversight and Assessment Framework are used to develop approaches and**		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	build strategies: The Trusts People Plan embed EDI throughout as a cross-cutting enabler, with key annual operational actions identified. A new Patient Experience & inclusion Plan was approved in 2025. These plans are regularly reviewed, and progress reported to Valuing Our People Council and Strategic People Committee. In additional new actions are developed as part of the annual responses to the WRES, WDES, Statutory Pay Gap, and Staff Survey Assessments. Action plans are developed and signed off at the relevant level. 5. **Equality and health inequalities are reflected in the organisational business plans to help shape work to address needs:** The Trust overarching aim is to provide "5 Star Patient Care" which underpins all our activity. In 2024, the new Trust Values were published including "We are Inclusive". The key organisational strategies to address EDI and HE are the Patient Experience and Inclusion Strategy, and the HR People Plan.		
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	1. **Board members, system and senior leaders ensure the implementation and monitoring of the relevant below tools.:** • WRES • WDES • NHS Oversight and Assessment Framework • Impact Assessments, • Gender Pay Gap reporting, • Staff risk assessments (for each relevant protected characteristic), • End of employment exit interviews • PCREF (Mental Health), • EDS • Accessible Information Standard, • Partnership working – Place Based Approaches The Trust's governance structures include the Patient Experience Council, People Performance Council, Valuing Our People Council, Strategic People Committee, Executive Committee, and the Trust Board. Through these bodies EDI and HI initiatives are reviewed, approved and monitored. For example, the Board receives and approves the EDS, WRES, WDES, and Statutory Pay Gap reports. The Strategic People Committee (a Board Sub-Committee) receives reports on the WRES, WDES, High Impact Actions, Sexual Safety	2	Human Resources Patient Inclusion & Experience Governance Team Board/Trust Exec

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Charter, Pay Gaps, HR/Staffing Metrics including Turnover and approve action plans. The People Performance Council (PPC), Valuing our People Council (VOPC), and Patient Experience Council respectively receive and review for assurance quarterly updates and annual reports of key initiatives (WDES, WRES etc). 2. **Interventions for unmet goals and objectives are present for the relevant listed above tools**: The HR People Plan and Patient Experience & Inclusion Strategy, plus their annual operation plans and commitments, incorporate any new EDI actions to address and respond to gaps identified by these tools. Additional actions may also be incorporated in the Staff Survey action plan, and other operational plans. 3. **Board members, system and senior leaders actively support those experiencing the menopause within the working environment**: The Trust has a Menopause Policy, and an active Menopause Network with over 350+ members. The network has a regular on-going programme of events and meets online regularly to discuss topics relevant to its members. Alongside this they run events for World Menopause Day and are supported by the Health Work and Wellbeing Team who provide advice and support. 4. **Organisations work with system partners to refocus work, to meet unmet need and demonstrates change**: The Trust works with numerous system partners including the Cheshire & Merseyside ICB and local Trusts, NHS NW EDI and NHS England EDI teams, Health Watch groups for all the local boroughs. Health Watch are members of a number of Trust councils/committees (e.g. Equality Steering Group) and take part in patient voice engagement activities with the Patient Experience & Inclusion Team to ensure the patient voice is heard. Similarly trade union colleagues are members of numerous meetings/committees (e.g. Policy Sub-Group, Equality Steering Group) to ensure the staff voice is heard. 5. **Those holding roles at AFC Band 8C and above (for Achieving) or 7 and above (for Excelling) are reflective of the population served.** Agenda for Change is the pay scale used by all non-medical employees in the NHS. 17.4% of the AfC workforce is Band 7-9 and 0.9% are Band 8C-9. • **Band 8C+:** Compared to the local population (Knowsley, St Helens, Sefton, West Lancashire) there is a higher proportion of 30-39, 40-49 (significantly), and 50-59 (significantly) year		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	olds, BAME, Women, Hindu, Jewish, and Other Religion. There are significantly fewer Known Disability. There are no known 16–24-year-olds within the band grouping. • **Band 7+:** Compared to the local population (Knowsley, St Helens, Sefton, West Lancashire) there is a higher proportion of BAME, Women (significantly), LGBO, Jewish, Hindu, Muslim, Other Religion, and staff aged 30-59-year-olds. There are significantly fewer Men, Known Disability, 18-24-, and 60–64-year-olds within this band grouping. **6. Organisations are able to show year on year improvement using Gender Pay Gap reporting, WRES and WDES.** a. WRES: 7/13 indicates have 2-year improvement (2024 and 2025), with 5/13 with 3 year improvements (2023, 2024 and 2025). b. WDES: 6/15 indicates have 2-year improvement, (2024 and 2025) with 6/15 with 3-year improvements (2023, 2024 and 2025) . c. GPG: Positive improvement in 6/10 indicators, with 4-year reduction in Mean (2022-2025), 5-year reduction or 0% in Median (2021-2025), 3-year reduction in Bonus Mean (2023-2025), 4-year 0% Bonus Median (2022-2024); increases in % Men in Q1 (2022-2025), and Q2 (2021-2025). **7. Board members, system and senior leaders monitor the implementation and impact of actions required and raised by the above listed tools.** EDI and Health Inequality agenda items are regularly discussed at the Trust patient and workforce governance committees and the following reports are standing items in the annual committee business • Pay Gap (Disability, Ethnicity, Gender, Sexuality); Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES); Sexual Safety Charter implementation. • Patient EDI & Inclusion Reports; Freedom to Speak Up; Safeguarding; Violence Reduction Strategy. • Service updates on Maternity. Children, Young People, Women's & Children's Health, Primary Care, Learning Disability & Mental Health, Chaplaincy etc. • EDI Action Plans are regularly monitored by The People Performance Council (PPC), Valuing our People Council		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	(VOPC), Strategic People Council (SPS), and Patient Experience Council.		
Domain 3: Inclusive leadership overall rating		2	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): • Union members of peer review panel • Union members of People Performance Council	**Independent Evaluator(s)/Peer Reviewer(s):** • Peer Review Panel

2.6. EDS Action Plan

EDS Lead	Year(s) active
• Darren Mooney - Head of Equality, Diversity & Inclusion (Workforce) • Cheryl Farmer - Head of Patient Inclusion and Experience	2025-2026
EDS Sponsor	**Authorisation date**
• Malise Szpakowska – Chief People Officer • Sarah O'Brien – Chief Nursing Officer	February 2026

2.6.1. Domain 1

Diabetes and Endocrinology Teams

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Consistent information provided to patients across sites. Easy read information being accessible to patients.	Review patient information leaflets across all sites and where possible, merge leaflets to ensure circulation across all sites. Increase the number of easy read leaflets within the department.	Dec 2026 Dec 2026
	1B: Individual patients (service users) health needs are met			

	1C: When patients (service users) use the service, they are free from harm				
	1D: Patients (service users) report positive experiences of the service	Increase patient feedback (S&O sites)	Embed the use of FFT within the service.	Dec 2026	

Radiology Service

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Easy read information being accessible to patients	Increase the number of easy read leaflets within the department	Dec 2026
	1B: Individual patients (service users) health needs are met			
	1C: When patients (service users) use the service, they are free from harm			
	1D: Patients (service users) report positive experiences of the service	n/a		

Interpreting Service

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Increase the number of interpreters and languages spoken to improve patients access to the service	Continue working with the providers and monitoring recruitment activity = particularly rare languages	ongoing
	1B: Individual patients (service users) health needs are met	Increase the access to video interpreting across the Trust including iPads that are dedicated to this purpose and speakers that can be used on desktops in clinic area	Task and finish group to be set up to look at increasing access to the video service, but also need to work with staff who refuse to use this service	January 2027

	1C: When patients (service users) use the service, they are free from harm	Ensure staff have the necessary skills to work with interpreters and know when an interpreter is essential throughout the patient journey Identify any gaps in methods of communication that may disadvantage patients with additional communication needs	Continue delivering the 'How to work with interpreters' to all grades of staff across all sites Identify, highlight and address any gaps picked up while carrying out the Trust accessibility project in all services/all sites	Both ongoing as large scale projects
	1D: Patients (service users) report positive experiences of the service	Increase patient feedback	Extend the number of patients with different languages we survey and survey more regularly	December 2026

2.6.2. Domain 2

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Improve Health Inequalities data capture and analysis for staff	• Agree standard EDI/OH reports • Further develop Wellbeing Pages of listed conditions	Dec 2026 Dec 2026
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Reduce incidents of bullying and harassment	• Run a Trust wide Zero Tolerance Campaign • Introduce Sexual Misconduct Policy • Deliver Trauma Informed Sexual Safety Training to specialist staff	Dec 2026 June 2026 Dec 2026
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Ensure up to date information is available to staff, and sign posting	• Continue to develop HWWB/OH web resources • Adopt new Staff Network Framework • Re-Launch Staff Networks	Ongoing July 2026 July 2026
	2D: Staff recommend the organisation as a place to work and receive treatment	To increase staff satisfaction with EDI practices	• Continue to implement new exit interview process and review data/feedback	Ongoing

2.6.3. Domain 3

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To increase all staff members EDI competence	• Publish EDI Training Programme for 2026-2027 • Repeat EDI Appraisal Training Objective • Develop self-learning / eLearning materials from current training offer to allow staff self-directed learning	April 2026 Nov 2026 March 2027
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To ensure and equip senior leaders to understand the equality impact assessment process	• Equality Impact Assessment training to be completed by senior leaders • Review and develop EIA webpages and toolkit • Introduce updated Quality Impact Assessment Process Policy/SOP	Dec 2026
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To ensure that EDI data is readily available and accessible when needed	• To create standardised EDI workforce data dashboard • To review annual PSED Report and data provided and presentation	Dec 2026
		Improve EDI Governance and Staff Network structures	• Launch a new EDI Council, and sub-committees • Senior Leaders identified as designated staff network champions • Adopt new Staff Network Framework • Re-Launch Staff Networks	July 2026
		System Working	• Launch St Helens Healthcare Hub • Establish a C&M EDI Workforce Leads Network • Implement new Work Experience Policy and building relationship with schools/colleges	Aug 2026 April 2026 Dec 2026