



CESHIRE & MERSEY

**ADULT CRITICAL  
CARE NETWORK**

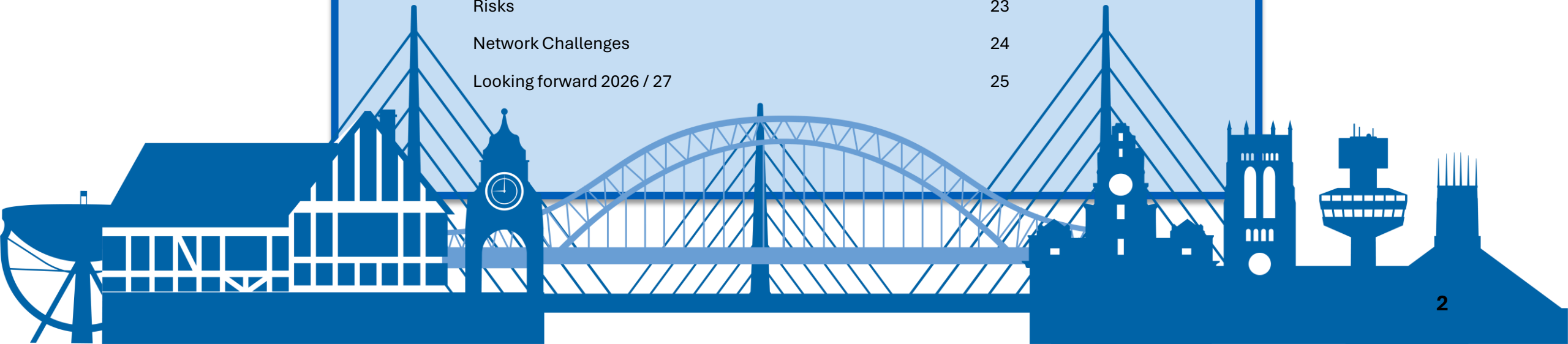


**Cheshire & Merseyside**  
Critical Care Network

# Cheshire & Mersey Critical Care Network Annual Report 2025 / 2026



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**Dr Tristan Cope**  
Medical Lead

## Foreword

I would like to thank all the Trusts and staff who have engaged with the network over the past 12 months. The network is not defined by the central team – Alexi, Karen, Lorraine and I are simply facilitators. It is the people within critical care across Cheshire, Merseyside & the Isle of Man who choose to collaborate with each other who deliver the outstanding work highlighted in this annual report.

This year has presented significant challenges for us all. Workforce pressures have continued to affect our services, with difficulties in recruitment, retention, and sustaining a resilient skill mix, with an accompanying impact on staff wellbeing and moral. These pressures have been compounded by ongoing NHS financial constraints and large-scale organisational change locally, regionally and nationally. Changes to bank staff payment rates have required services to implement mitigation measures to maintain safe staffing in an already constrained workforce environment.

"Winter pressures" have been felt throughout the year, alongside a shift in the acuity and complexity of patients admitted to our units. Challenges with flow through hospitals, including delayed transfers of care, have continued to impact the ability of units to step down patients in a timely way, which in turn has an impact on available capacity. Despite this, our peer review programme has demonstrated that units across the network continue to deliver high-quality patient care while supporting staff to maintain these standards.

Thank you for the engagement, commitment, and collaboration shown over the past year. The excellent work detailed in this report clearly demonstrates the value of a Critical Care Network for our staff, our patients, and the wider health economy.

Thank you  
Tristan



## History

Cheshire & Mersey Critical Care Network (CMCCN) is one of the largest Critical Care Specialist Services Clinical Network (SSCN) in England and was established in 2003.

## The Team

The Core team of CMCCN consists of sessional input from a Medical Lead, a full time Lead Nurse, alongside the Specialist Services Clinical Network Director and Administration and Project Support Officer who both also support the Cheshire and Mersey Major Trauma Network (CMMTN).

## Board

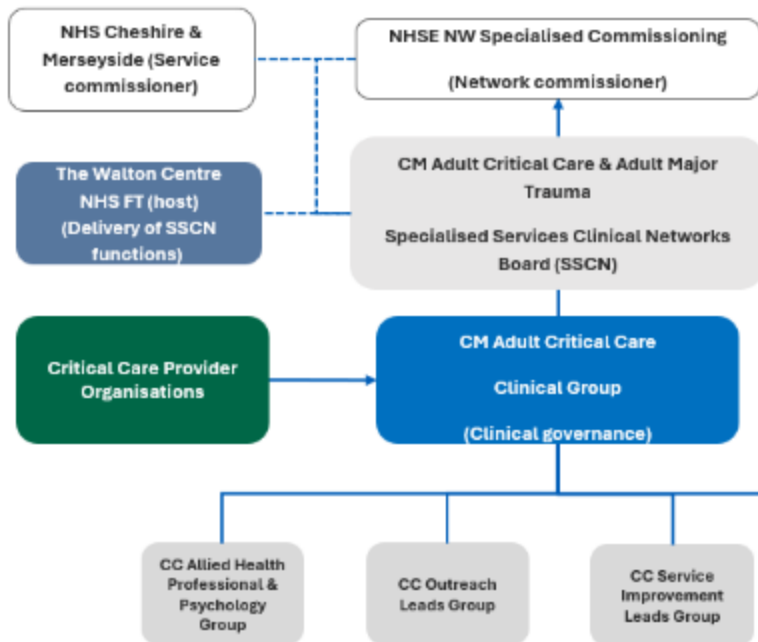
CMCCN shares a Board with CMMTN. It is Chaired by Jan Ross, the Chief Executive Officer of The Walton Centre NHS Foundation Trust and meets quarterly. Membership of the Board includes representation from the Cheshire & Merseyside (C&M) Integrated Care Board (ICB), NHS England (NHSE); specifically Commissioning and Emergency Preparedness, Resilience & Response (EPRR), Executive and Clinical Leads from Trusts that form the Networks.

## Our Role

CMCCN play a crucial role in coordinating patient pathways across providers to ensure equitable access to specialist resources & consistent delivery of care. They monitor standards, support service improvement, & act as a bridge between commissioners and providers to enhance quality and outcomes.

## Function

The network team leads, coordinates, and supports activities and developments engaging clinicians and other stakeholders within 11 critical care units in CMCCN which is pivotal to the delivery of a networked approach to delivering cross region critical care clinical pathways.



## Governance

Adult critical care (ACC) services are commissioned by ICBs and Critical Care Specialised Services Clinical Networks (SSCNs) are currently commissioned by NHSE. CMCCN is hosted by The Walton Centre NHS Foundation Trust.

The current governance structure of CMCCN is shown in the diagram on the left. The main governance group of the network is the Critical Care Clinical Group (CCCG) that meets quarterly, this feeds up to the Joint Board. In 2025 / 26 there were four groups that fed into the CCCG, the Allied Health Professionals (AHPs), Outreach Leads, Service Improvement Leads (SILs) and the Senior Nurses.



# Trusts in Cheshire & Merseyside Critical Care Network

The Cheshire and Merseyside Critical Care Network is made up for 11 Units across eight Trusts in Cheshire, Merseyside and critical care services in the crown principality of the Isle of Man shown in the map below and serves a population of 2.3 million. It has common boundaries with parts of Greater Manchester, Lancashire, West Midlands and North Wales with a catchment population of approximately 2.7 million. The provider trusts range from large city centre critical care units with multiple specialities to small specialist trusts where critical care may be a large part of their in-patient population to DGHs providing general services to their local population. Nobles Hospital has additional challenges due to its geographical isolation and the island's status as a Crown Dependency.

No. on Map	Unit	Trust	Level 3	Level 2	Total Beds
3	Aintree University Hospital	NHS University Hospitals of Liverpool Group	14	12	26
7	Arrowe Park Hospital	Wirral University Teaching Hospital NHS Trust	6	12	18
9	Countess of Chester	Countess of Chester NHS Foundation Trust	8	7	15
10	Leighton	Mid-Cheshire NHS Foundation Trust	7	4	11
6	Liverpool Heart and Chest Hospital	NHS University Hospitals of Liverpool Group	18	12	30
2	Nobles Hospital	Manx Care	2	4	6
5	Royal Liverpool University Hospital	NHS University Hospitals of Liverpool Group	17	16	33
1	Southport Hospital	Mersey and West Lancashire Teaching Hospitals NHS Trust	5	6	11
3	Walton Centre	Walton Centre NHS Foundation Trust	16	4	20
8	Warrington Hospital	North Cheshire & Mersey NHS Foundation Trust	7	10	17
4	Whiston Hospital	Mersey and West Lancashire Teaching Hospitals NHS Trust	8	6	14

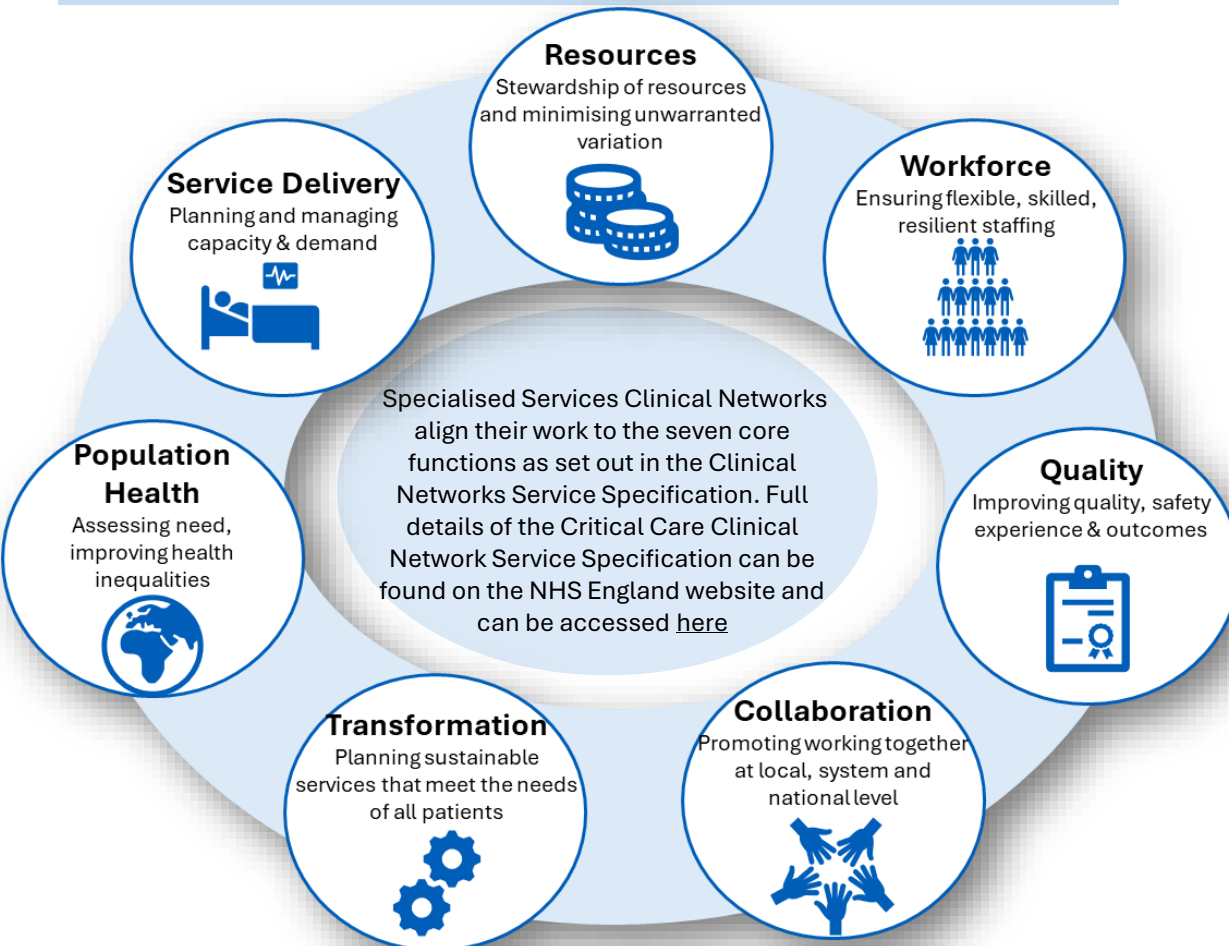


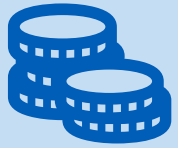
The 'Overview of the Year' section of the annual report is going to highlight some of the work completed throughout 2025 / 2026. The network develops an annual workplan which much of the activity is derived from. It should be noted that much of the Network's work spans multiple functions. For the purposes of this Annual Report, activity has been aligned to the function that best reflects its primary focus, with emphasis placed on key high impact areas rather than providing an exhaustive account for all work undertaken.



## Service Delivery: plan and manage capacity and demand

- **Delayed Discharge** data submitted quarterly to the CMCCN core team, is analysed and shared quarterly. A full annual report was produced and shared with our stakeholders
- Trust surge plans were reviewed and confirmed prior to the start of the winter period, ensuring Trusts had **robust capacity plans** in place to deal with increases in demand. Commissioned bed base numbers were checked as levels of care often require the critical care bed base to be flexible with demand.
- Work was completed with Integrated Care System (ICS) colleagues to ensure that data was pulling correctly from ACC data systems to the regional **SHREWD dashboard**. Providing an accurate real time picture of ACC services across Cheshire & Merseyside (C&M)
- The CMCCN **transfer vehicle** that is facilitated in conjunction with Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH) and Sparks Medical continued to run in 2025/26.
- CMCCN **monitors the capacity transfers** within the system, and they are all reported into the CMCCN team. The data collection on all critical care transfers is analysed and shared across the network.
- Continuation of the Service Improvement Leads (SIL) **annual audit programme** which includes monthly transfer data, delayed discharge data, staff moves, sickness and vacancy data within all our units. This data is analysed, benchmarked and circulated to all our stakeholders. The introduction of the observation of care audits have allowed the SILS to visit and audit each other's units on key priorities in critical care patient care.
- CMCCN continue to have links with **EPRR** leads within NHS England (NHSE) and C&M ICB, there is now a clear escalation pathway to escalate critical care issues to the team and act as advisors to the team when needed.
- CMCCN continue to maintain oversight of **Directory of Service (DOS) and National Commissioning Data Repository (NCDR)** critical care bed occupancy dashboard. The DOS dashboard is updated twice daily and gives a true picture of bed occupancy nationally, regionally and at network level. The NCDR dashboard is used to inform, facilitate and monitor requests for mutual aid and capacity.





## Resources: clinical stewardship of resources across whole pathway

- The National Case Mix Programme (CMP) publishes a quality dashboard part of this shows the rate of **discharges directly home**.

The chart shows the data from April – September 2025 and it indicates that C&M Units are above the national average for discharges directly home. Whilst patients should not be directly discharged home from critical care and should be stepped down to a ward it is now happening on a regular basis in the majority of CMCCN units. Therefore, CMCCN set up a multidisciplinary team (MDT) working group to look at how we can facilitate safe discharges home directly from critical care. The group developed and published the following documents :

- ✓ Best Practice Guidance Document in safe facilitation of discharge of patients directly home from Critical Care
- ✓ Checklist for critical care staff to use to ensure all elements of a safe discharge home have been done.

There was also a Pilot of a Critical Care Outreach team follow up service for patients directly discharged home from Critical Care. Following a successful pilot, there are plans to roll this out across all CMCCN units.

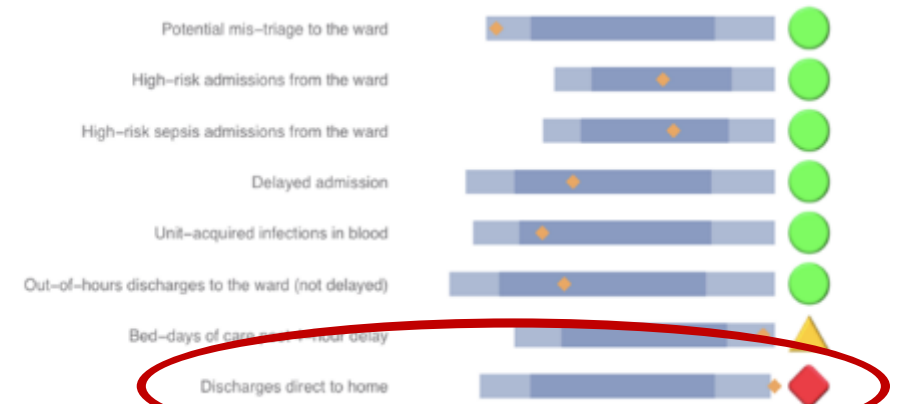
Other Projects that aligned to resources:

- **Peer Review**
- **Stakeholder Groups**; CMCCN also pride themselves in the amount of stakeholder meetings which demonstrates the high level of engagement we have with our teams within Cheshire and Mersey. Our stakeholder groups encompass all roles within the critical care MDT and provides a forum to standardise, promote and share best practice in patient care across the entire network.

Cheshire & Mersey Critical Care Network Report  
Network Quality Report: 1 April 2025 to 30 September 2025



## Quality indicator dashboard





## Workforce: flexible, skilled, resilient staffing

- CMCCN facilitate an **annual critical care staff retention survey**, led by the CMCCN lead Nurse and facilitated within the units by each LSIL.

The survey received 514 responses across 10 CMCCN units – 80% of the respondents came from Registered Nursing. A full network report was written and presented to key stakeholder groups.

- Within CMCCN **core unit nurse staffing data** is collected at unit level, collated and analysed and data graphs produced. Categories include :
  - Number of vacancies by banding
  - Percentage of nurse sickness by unit
  - Number of new staff by banding for each unit
  - Numbers of nursing staff moves to other wards / departments by unit. This is cited in the top 3 reasons why nursing staff leave the critical care speciality and this also provides a mechanism for units to benchmark in how many staff are moved each month.
- Providers of **Safe Critical Care Transfer Training (SCITT)** have assisted other units in the setting up of their transfer Simulation days. SCITT simulation days are now available in all CMCCN critical care units.

- CMCCN continue to have a focus on supporting our critical care workforce to thrive and ensuring their health and well-being is a priority. This includes supporting Professional Nurse Advocates (PNAs) and monthly check ins for the CMCCN senior nurses. We continue to develop resources and share best practice on supporting staff in practice.
- The Network lead nurse works closely with our local Higher Education Institutes (HEIs) to ensure post graduate programmes reflect the **National critical care education standards** and proficiencies.
- Trusts were supported by the CMCCN central team to submit their staffing data to the **National Adult Critical Care (ACC) census**. Which will give a clear picture of staffing across C&M.
- CMCCN continue to work with Trusts to ensure that they maintain their compliance of the number of nurses with a **post graduate critical care nursing** certification, the cut in funding has impacted on all Trusts.
- CMCCN stakeholders were involved in the **national review of the national critical care nursing competences**, including, Step 4 Leadership Competences, trauma, health care assistant, cardiac and neuro.
- 11 of CMCCN units have now using the step competences **digital platform** which is a great achievement compared to some other networks in the country.





## Quality: improve quality, safety, experience and outcomes

- Quality runs through all the projects that CMCCN deliver annually Units shared areas of excellence during the 2025/26 **Peer Review** also this process gave the opportunity to see the quality of the services provided across C&M.
- All CMCCN units contribute to the **Intensive Care National Audit & Research Centre (ICNARC)** data collection, the focus is on people who are likely to become, currently are, or are recovering from being critically ill. There are network wide reports which help inform us about CMCCN care and treatment outcomes. The data sharing agreement is now in place, so this allows the CMCCN team access to all the unit reports to look at key themes and commonalities across the network. The data collection helps drive quality improvement to improve patient care and ensure it is safe and effective.
- Network incidents** are monitored through the CMCCN governance structure, this provides a structured and objective approach to reviewing any practice considered to be sub-optimal and utilising outcomes to learn, share and inform future practice. Lessons learnt from incidents are shared within the quarterly CMCCN Clinical Group Meeting.
- Quality improvement** is a key to the network, within Units the Service Improvement Leads (SILs) have dedicated time to lead on projects, in addition they complete Network wide audits and collect data.



## Transformation: plan sustainable services that meet the needs of all patients

- CMCCN is the subject matter expert in Critical Care services across C&M. A regional project that the network has been involved in during 2025 / 26 is the continued **Liverpool Women's Hospital** service Transformation work looking at their case for change. Day to day CMCCN continue to support the Trust on their service delivery of critical care services.
- The **discharge directly home** project that has been previously mentioned during this report really illustrates CMCCNs drive for transformation as with many of the deliverables it spans more than just one of the seven core functions.
- CMCCN ensure that the **patient and relative voice** is heard within transformation projects by utilising the local Intensive Care Unit (ICU) Steps, patient and relative support groups at Southport, Whiston critical care units and the patient and relative support group at Warrington Critical Care Unit. The CMCCN Patient and Public policy has been updated which ensures Patients are completely at the centre of all the networks core functions and the networks work programme
- An ongoing project that is referenced later in the annual report is the design and implementation of the **NW Critical Care Dashboard**. The unique selling point of this dashboard is to pull many points of data from various tools together. It draws on all national Critical Care data tools such as DOS and NCDR. This also allows for retrospective bed occupancy data from the NCDR and DOS systems to be collated.

## Population Health; Assessing need, improving inequalities in health access, experience and outcomes



- CMCCN continue to work to **improve health inequalities** across C&M, this is mainly via ensuring equitable access and experience when a person receives critical care. The 2025 / 26 Peer Reviews highlight the quality and any gaps in provision of services. These have then been shared with Units and their Executive Leads. Further work will continue into 2026 /27 to identify any specific project that result from the peer review process.
- Access to data showing population health continues to be a challenge. However, the 2025 Census data did show that when compared with the rest of Country the NW had lower critical care beds per 100,000 population compared with some areas of the country this is something that needs to be monitored. CMCCN will continue to work with Trusts to ensure that they have the right number and level of beds within their Units.
- CMCCN continue to work with their colleagues in the NW to develop the NW Critical Care Dashboard to include population health data such as deprivation which can be an indication of higher health needs.
- The NHSE Specialist Services Oversight and Reporting (SSORT) Tool provides assurance on the quality of care by collecting information about specific critical care outcomes from healthcare providers for example delayed discharges and rehabilitation. It is a key tool in monitoring the quality of services, enabling comparison between service providers and supporting improvements over time in the outcomes of services commissioned by NHS England.



## Collaboration; Promoting working together at local, system and national level

- CMCCN demonstrated the high level of collaborative work that they delivered in 2025 /26 by the **number of people who contributed** to the writing of the third edition of the Guidelines for the Provision of Intensive Care Services (GPICS) which was published in January 2026. The table on the right shows the details of the people and the sections they completed.
- CMCCN continues to achieve **high levels of engagement** from key stakeholders within all network groups and forums. In addition to the designated Critical Care personnel there is additional engagement from other specialities where this is required to inform and develop practice or pathways for example, cardiac, respiratory, and renal.
- CMCCN work collaboratively regionally and nationally to improve services for our staff and patients. Examples of this are:
  - **Paediatric critical care education** events to ensure ACC staff have the necessary knowledge and skills to look after paediatric patients in Units in times of surge and high demand in paediatric critical care beds.
  - Workstreams with **C&M Rehabilitation Network** in relation to critical care rehabilitation workstreams and education.
  - National projects looking at **Self Assessment and Peer Review Core Principles**.
- CMCCN continue to be involved in a broad breadth of **national groups** to ensure that the voice of C&M is involved in the sharing of best practice, we input into the following groups; National AHP Group, National Critical Care Managers, Critical Care National Network Nurse Leads Forum (CC3N), National Pharmacist Group, National Critical Care Nursing Education and Research Forum (CCNERF).
- The work CMCCN does with local Intensive Care Unit (ICU) Steps, patient and relative support groups also demonstrates the collaborative approach of CMCCN

Guidelines for the Provision of Intensive Care Services 3				
Chapter	Title	Name	Job Title	Trust
1:9	Neurocritical Care	Sandeep Lakhani	Consultant	The Walton Centre
1:10	Burns Care	Ascanio Tridente	Consultant	MWL; Whiston
2:5	Registered Nurse Staffing	Karen McMullen as part of UKCCNA	Lead Nurse	Critical Care Network
2:6	Registered Nursing Associates	Karen McMullen	Lead Nurse	Critical Care Network
2:7	Pharmacy; Section Editor	Greg Barton	Principal Clinical Pharmacist	MWL; Whiston
3:5	Airway Management	Andrew Higgs	Consultant	Warrington
4:4	Patient Safety Standards	Peter Bamford	Consultant	Countess
4:5	Environmental Sustainability	Sam Clarke	Consultant	Leighton
5:2	Surge & Business Continuity Planning	Ascanio Tridente	Consultant	MWL; Whiston



# Peer Reviews; Process

## Prework

- Central network team developed the peer review metrics based on 33 documents.
- There were 257 indicators across 29 sections.
- Individuals were recruited to form the peer review panels; 29 people from 10 Trusts.
- Peer Review metrics were shared with Trusts to complete prior to their review with the expectation they self-assessed themselves.
- Trusts were asked to prepare a presentation covering challenges, best practice, activity and key projects such as Martha's Rule.

## Face to Face Review

- The face-to-face review was split into three main sections:
  1. Critical Care Unit Presentation
  2. Multidisciplinary Team (MDT) Service Specification & Peer Review documentation review breakout sessions
  3. Review panel feedback
- Following the review the central network team have analysed the findings from the three sections. The percentage compliance score was calculated for each section and then RAG rated, achievements, good practice and challenges have been identified and recommendations developed for each non-compliant indicator.

## Post Review

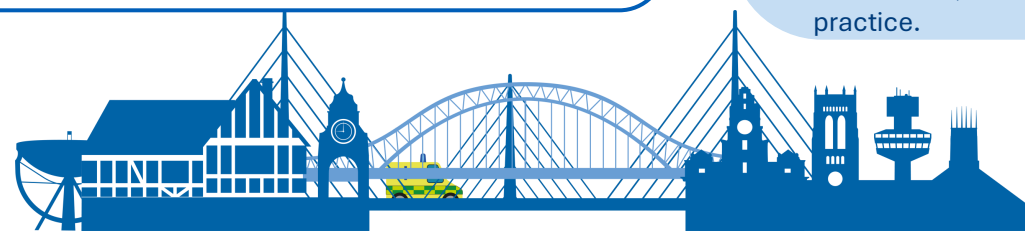
- The central network team authored individual reports for each Trust including a recommendation for each indicator they did not achieve.
- There were 78 different recommendations across 19 sections.
- A survey was circulated following the peer review process to gain feedback from all stakeholders. This feedback will be used to amend the peer review process for future cycles.

### Example Recommendations;

- Plans should be made to increase the rehabilitation service to seven days a week when required. If patients are not receiving required management, then it should be formally recorded and escalated appropriately, including on relevant risk registers.
- Ensure that the establishment of the Unit supports the correct skill mix of staff to perform duties associated with their role.
- The Unit to have plans in place to provide basic critical care assistant training for non-critical care personnel for situations where escalation is necessary.
- Continue with the planning to improve single sex accommodation. Ensure that breaches are recorded appropriately.
- Increase current compliance against the numbers of Registered Nurses that hold a Post Graduate qualification in Critical Care Nursing.

### Example Evaluation Survey Comments;

- I find the peer reviews very helpful and non challenging. They assist in my ability to benchmark against GPICS as it becomes promptly on the executive radar.
- We did not receive the guidance. Ward manager informed us about it.
- Fewer but more focused indicators would be more sensible - many indicators appeared repetitive, out-dated or irrelevant
- It flowed well and I felt captured good range of information and feedback.
- The report highlights the strength and weaknesses and gives us a direction for future development.
- We do not meet GPICs with our current service provision, so it is useful to have it clearly documented from the network.
- It highlighted our challenges and gave us focus to address any issues raised. Also, to celebrate and feel supported with feedback of good practice.



# Peer Review; Key Achievements & Challenges



## Aintree University Hospital

### Achievements & Good Practice

- All static band 6 & 7 AHPs have completed the relevant critical care course.
- The Unit is compliant with Dietetics cover.
- A weekly huddle has been implemented with staff saying this provides them with the opportunity for face-to-face safety learning.
- Robust clinical governance was evidenced.
- The unit is actively involved in the Trusts, EPRR exercises.
- Progress against the recommendations from the previous peer review:
  - Newly appointed Transfer Leads; Safe Critically Ill Transfer Training (SCITT) started July 2025.
  - Reduction in the numbers of non-clinical transfers.
  - Increase in the compliance of the number of staff who have achieved a post registration critical care nursing award to 50%

### Challenges

- Gaps in the administration team have impacted on the national and local data submissions.
- Non-compliance against GPICS standards for psychology, physiotherapy, pharmacy & speech and language
- The Trust is not currently part of the Martha's Rule Pilot



## Arrowe Park Hospital

### Achievements & Good Practice

- There was much evidence of excellent care of patients – examples of this are the newly decorated interview room and the charitable bid in progress to renovate the outside area for use by patients.
- Overwhelming evidence of the Unit supporting their staff:
  - Staff boards which provide information and are regularly updated
  - Monthly newsletters
  - Staff wellbeing support group
  - Celebration of international nurses; nurses from 20 different countries.
- 80% compliance of the number of staff who have achieved a post registration critical care nursing award.
- Turnover and Sickness rates have been reduced.
- Martha's Rule has been successfully embedded across the Trust.

### Challenges

- The Unit's estate poses an ongoing concern regarding compliance with HBN 04-02 critical care unit facilities; however, improvements have taken place on the ventilation system.
- There are some periods where nursing ratios are stretched outside of GPICs – this should only be in extreme circumstances only.



## Countess of Chester Hospital

### Achievements & Good Practice

- Excellent care of patients with staff responding to specific wants and needs of their patients, examples being: Patient balcony project; Blues Skies Appeal Clear and accessible patient resources Patient memorial service. Low number of concerns and only one complaint since sept 2023.
- Overwhelming evidence of the Unit supporting their staff:
  - Team promotions
  - Staff boards
  - Use of Ted Tool
  - Freedom to speak up guardians at every staff level.
  - Staff initiatives; social gatherings, hug in a mug, problems and solutions box
  - Celebrations of international staff.
- 55% compliance of the number of staff who have achieved a post registration critical care nursing award.

### Challenges

- The Unit has gaps in AHP support, however; the Trust is taking a risk management approach by datixing any incidents to support submitted business cases.
- Delayed discharges were highlighted as an issue.



## Leighton Hospital

### Achievements & Good Practice

- A drive for quality improvement was clearly demonstrated.
- Excellent engagement between the Unit and Management in the Trust.
- The Unit has extended on-site Consultant cover to 8.30pm to extend presence of senior doctor and mitigate junior doctor staffing.
- The Trust has been approved for Stage One & Two of Intensive Care Medicine Training.
- 53% compliance of the number of staff who have achieved a post registration critical care nursing award.
- Improvements in core data submissions.
- Staff engagement was evidenced with:
  - Staff awards
  - Critical Care Newsletter
  - Information Boards; research, use of QR codes
  - Certificates of Recognition
  - Much evidence of individualised care for patients

### Challenges

- Lack of funding for AHP cover
- Aging workforce that impacts Medical and Nursing staff
- Limited administration support for the Unit.



## Liverpool Heart & Chest Hospital

### Achievements & Good Practice

- There is broad attendance in the MDT.
- The Unit has an Advanced Critical Care Practitioner (ACCP) Physiotherapist, which adds a different dimension to the role.
- Physiotherapy plans are reviewed every three days rather than seven.
- Ring fenced hours for deputies to provide experience.
- Increased the level of dietetic support to ensure that they meet the standard.
- Despite not being part of the Martha's Rule pilot, the Trust has invested in implementing Call for Concern.
- Excellent, holistic and collaborative care for their patients with examples of this being:
  - Excellent facilities including a garden
  - Easy read patient information
  - Preoperative visit for elective patients to explain what they should expect
  - Patients are invited to a post discharge afternoon tea

### Challenges

- The Unit does not have a Rehabilitation Coordinator in post.
- The physiotherapy service is still under GPICs, and the team is moving to provide a seven-day service with no additional resource.



## Royal Liverpool University Hospital

### Achievements & Good Practice

- There was much evidence of excellent care of patient's – an example of this is the enhanced care areas and the excellent relative's satisfaction survey.
- There was much evidence of great collaboration between the physiotherapist and occupational therapist (OT). With the Unit being one of two in the region to have an OT service.
- Regular Tracheostomy MDT rounds
- Martha's Rule has been rolled out to four surgical wards with medical ward implementation imminent.
- The Unit has improved the numbers of staff receiving SCITT training.
- There has been an improvement in the Unit's staff retention.
- Overwhelming evidence of the Unit supporting their staff:
  - Celebrate their teams' achievements
  - Workforce career path

### Challenges

- Non-compliance against GPICs for all AHPs
- There is currently no Rehabilitation Co-Ordinator.
- There are a number of staff groups who have not met the level of training compliance.

# Peer Review; Key Achievements & Challenges



## Southport Hospital

### Achievements & Good Practice

- Excellent engagement between the Unit and Management in the Trust and great links with other areas in the Trust.
- An MDT focus with support from the operational team.
- The Outreach Team support teaching and learning across the Trust.
- Focus on patient rehabilitation.
- Excellent care of patients providing examples of when they go that extra mile:
  - No complaints received in three years
  - Resources for patients such as heart rhythm tube, spiritual care booklet
  - Bereavement clinic
  - Ex patient volunteering to support staff and patients.
  - 65% of compliance of the number of staff who have achieved a post registration critical care nursing award.
  - The Unit came across as creative and with a massive focus on service improvements.

### Challenges

- Medical staffing recruitment remains a challenge
- The Unit's estate poses an ongoing concern with regard to space, building regulations, and mix sexed accommodation.



## Walton Centre

### Achievements & Good Practice

- There is a well-developed ACCP team.
- Great education team with a robust programme of MDT teaching.
- Static Band 7 Physio providing lung ultrasound
- SALT input on the unit, despite no funding.
- Overwhelming evidence of the Unit supporting their staff:
  - Opportunity for staff health and lifestyle checks
  - New night staff are offered additional support
  - Staff counselling available
  - Coffee and a catch up
- Excellent care of patients with staff responding to specific wants and needs of their patients, examples being:
  - Patient garden and garden room
  - End of life planning
  - Pet Policy
  - Patient feedback is themed and change projects put in place

### Challenges

- AHP's are not funded apart from physiotherapy.
- The high dependency unit is not non-compliant on HBN 04-02 for critical care facilities.
- There is currently under 50% compliance of the number of staff who have achieved a post registration critical care nursing award.



## Warrington Hospital

### Achievements & Good Practice

- 5 qualified ACCPs who are airway trained.
- The outreach team commits to seeing patients within 12 hours rather than 48.
- Clear focus on education with an ICU education week, emphasis on bedside teaching.
- Overwhelming evidence of the Unit supporting their staff:
  - Staff boards which provide information and are regularly updated
  - Annual ICU week which involves a different activity every day; coffee & cake, teaching, competitions.
  - Bollywood Ball for overseas nurses
- Excellent care of patients with staff responding to specific wants and needs of their patients, examples being:
  - Patient garden project which is in progress due to staff fund raising.
  - Clear & accessible patient resources
  - Patient memorial service which includes a children's choir, poems and nurses singing.
  - End of life planning

### Challenges

- Delayed discharges were highlighted as an issue.
- The Unit has gaps in AHP support.

# Peer Review; Key Achievements & Challenges



## Whiston Hospital

### Achievements & Good Practice

- Best attended governance meeting in the Trust from a clinical perspective demonstrated the feedback loop from; friends & family, clinic feedback, ICNARC data.
- The Unit has identified Leads for paediatrics, transfer, equipment, sepsis, governance, follow up, end of life, organ donation and data collection.
- There is a focus on quality improvement.
- The Unit has a qualified counsellor to provide care for staff and patients.
- 77% compliance of the number of staff who have achieved a post registration critical care nursing award.
- The Unit has their workforce at establishment.
- Positive start to implementing ACCPs; plans to increase numbers.
- Upgraded all B2 to B3

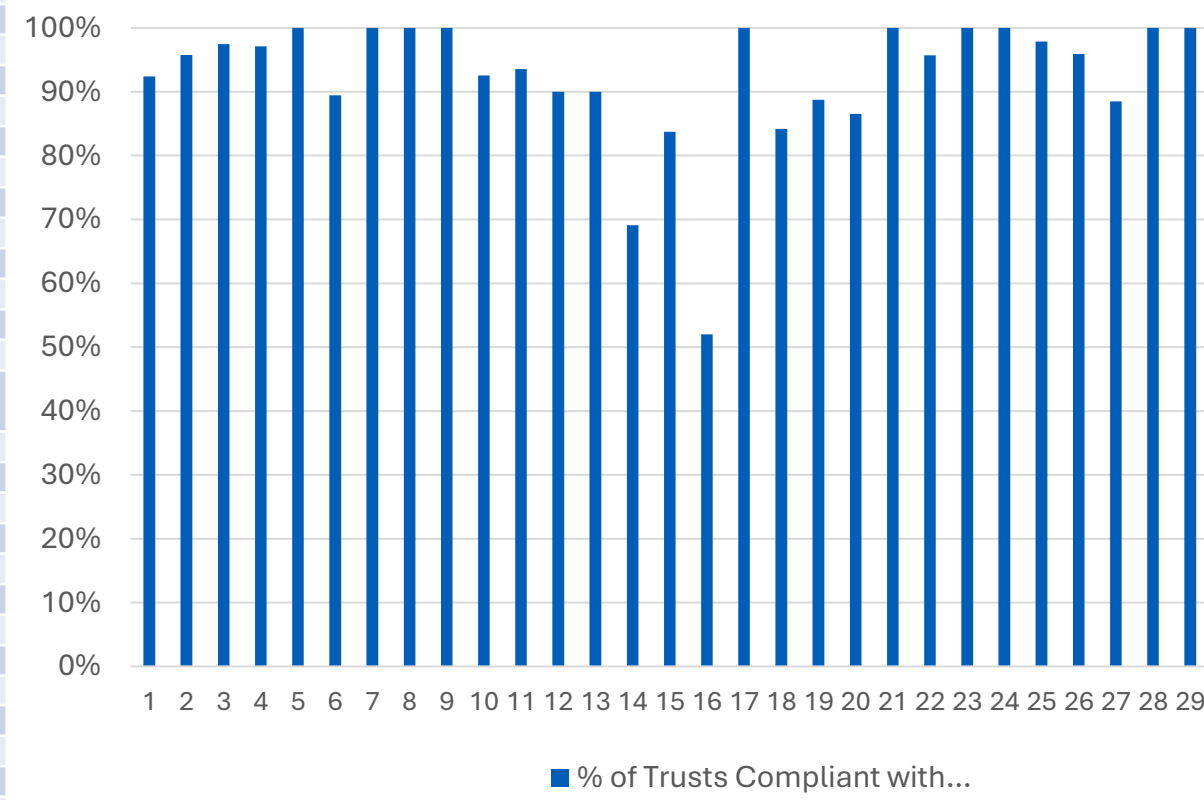
### Challenges

- Delayed discharges were highlighted as an issue.
- The use of critical care beds for non-critical care admissions.
- Staff moves are high within the Unit.

The chart shows the amalgamated percentage score for all 10 Trusts across all 29 indicators.

1	Facilities & Equipment
2	Operational Admission
3	Discharge from Critical Care
4	Transfer
5	Capacity Management
6	Clinical Governance
7	Legal Aspects of Capacity and Decision Making
8	Commissioning
9	Audit and Quality Improvement and CMCCN SILS Role
10	Medical Staffing
11	Registered Nurse Staffing
12	Health Care Support Workers
13	Other Support Roles
14	Allied Health Professionals (AHP) – Physiotherapists
15	AHP – Dieticians
16	Rehabilitation Coordinator, Speech and Language Therapy, Occupational Therapy and Psychology
17	Radiology and Imaging
18	Pharmacists
19	Outreach
20	Education and Training
21	Patient Carer Information
22	Infection Control
23	End of Life
24	Organ Donation
25	Compliance with National Clinical Guidelines
26	Staff Support and well being
27	Contingency Planning Surge and Business Continuity
28	CMCCN Groups
29	Data and audit collection / participation

Cheshire & Merseyside Peer & Specification Review



# Network Groups

## Allied Health Professionals & Psychology

**3** different Trusts Chaired the quarterly meeting during 2025 / 26.

**45** group members, from **11** Trusts.

Focused discussions looking at:

- **Early Management of tone and spasticity in a neuro critical care setting**
- **The Intensive Care Psychological Assessment Tool (IPAT)**
- **Supporting patients with altered airways to communicate Quality Improvement Project**
- **National Rehabilitation Commissioning Review**
- **Complex Case Presentations**

Other items looking at **Peer Reviews, SILS Annual Report, ACC Retention Survey, Delayed Discharge Report.**

Key updates shared at every meeting from:

- **National AHP Group**
- **C&M Physiotherapy Group**
- **NW Speech & Language Group**

### Challenges

- The main challenge experienced by all the professions in the AHP and Psychology workforce is the lack of service provision. This is due to gaps in funding to staff.
- There is a high level of variation of service provision across CMCCN.
- Those in post struggle to have nonclinical time to engage with CMCNN, so although there is a will to do collaborative network projects that would benefit patients the lack of time is the challenge.
- The lack of dedicated time for a lead in this group to link in with the Network.

## Senior Nurses

The Senior Nurse group hold meetings every quarter, changes have been made this year to reflect current pressures and to keep the great engagement. The meeting now runs for three hours with two face to face and two virtually. The group have also introduced a monthly peer support check in for an hour.

They have focused on collaborating and networking, demonstrating ways to ensure all the trusts in our network continue to adhere to very high standards. Also supporting new senior nurses joining the network and have created a culture of sharing information and supporting each other through our similar experiences.

Key projects delivered throughout 2025 / 26;

- **Deep dive** on newly published **GPICS 3**
- Continued MDT working groups for **discharge directly home**
- Introduction of **more PNAs** to promote restorative leadership
- Annual **CMCCN nursing retention survey** is continuing and feedback to individual units provided on request
- **Patient stories** being presented highlighting the impact on our patients to key stakeholders

### Challenges

- Organisation restructuring impacting on managers and nurse leaders
- Capacity of our Accident & Emergency Department's and the general wards often have an impact & leads to delayed discharges, out of hours discharges and direct discharges home.
- Financial constraints has led to reduced bank rates, agency nursing being stopped and overtime being scrutinised. This affects the workforce and wellbeing of our staff and can cause sickness and increased costs overall.
- Staff moves remain an issue due to fluctuating critical care capacity.
- Time to do the job of the matron within busy Units, pressure to reach targets and demonstrate outcomes.

## Critical Care Outreach Regional Network



The Critical Care Outreach Regional Group has made strong progress with a continued focus on standardisation, education, and improving patient safety across the network. A key strength has been the high level of regional collaboration, which has enabled shared learning, consistent approaches to care, and successful delivery of networkwide initiatives including:

- **Successful implementation of the national outreach competencies** across trusts, supported by an educational programme developed by the outreach group utilising specialities across the region
- **Significant advancement in tracheostomy care**, including the development and network updated best practice guidance alongside the creation of supporting tools such as tracheostomy and laryngectomy care plans and discharge checklists.
- **Strengthened its approach to data** and benchmarking, with all trusts now collecting a minimum dataset locally, enabling improved comparison and identification of improvement opportunities across the network
- **A draft workplan for 2026/2027** has been devised, the Critical Care Outreach Regional Network will focus on reducing variation in practice through the standardisation of ITU follow-up services, including the development and rollout of a unified follow-up protocol and patient diary. Alongside this, there will continue to be a strong emphasis on education and workforce development, with continued alignment to national competencies, delivery of a structured regional teaching programme, and evaluation of its impact on staff confidence and capability.
- One notable achievement has been the collaborative and **effective rollout of Martha's Rule** across the region. This has been supported by strong engagement between trusts, clear communication, and a shared commitment to improving patient safety and escalation processes.



### Challenges

- Some teams have challenges around staffing and ensuring the correct banding for the high level of autonomy & decision making needed in a Critical Care Outreach Team (CCOT)
- Ensuring CCOT have wider support across the Trust.

### Martha's Rule Implementation

**8** Trusts have rolled out Martha's Rule

**2** Trusts have applied to be part of the second wave.

**3** components to Martha's Rule

1. **Patient Wellness Questionnaire (PWQ)**
2. **Call 4 Concern for Staff**
3. **Call for Concern for Patients**

#### Trust Highlights

##### Mid Cheshire

All **3** components are rolled out across adult in-patient wards. PWQ has been **digitalised** and goes live May 26

##### The Royal Liverpool

Pilot started in Nov 24. **Implemented across whole** Trust Oct 25. **53** calls Oct 25 – April 26

##### Countess of Chester

Have Received **111** calls to date (April 25 – March 26). **40** Call for Concerns requiring a CCO review = **36%** of the calls. Averaging 2.05 calls a week

##### The Walton Centre

Have Received **12** calls to date (Nov 25 – Feb 26).

##### Southport

Components **2 & 3** rolled out to all adult wards. Component 1 being trialled. **74** calls since March 24

##### Liverpool Heart & Chest

Component 3 rolled out Trust wide in **June 2025**. Rolled out component 2 in **Nov 2025**. Component 1 planned for 2026

##### Arrow Park

Components 2 & 3 rolled out to all adult wards. Component 1 planned for 2026



Listening to patients to keep them safe



# Network Groups; Service Improvement Leads

## Key Responsibilities

- Develop best practice
- Improve communication
- Enhance team working
- Audit & benchmarking
- Report & learn from incidents
- Implement National & Local Standards.

## Impact

- 1,480 projects since 2007  
Projects Include:
- Critical care unit induction video
  - Back to basics training
  - Transfer documentation improvements
  - Out of hours transfer standard operating procedure
  - Blood sampling project
  - Central line care
  - Follow up clinics

## Collaborative Approach

- Regular meetings
- Sharing best practice
- Cross unit audits

## SILs

- Established in 2007
- One day per week (7.5 hours)
- Funded by Units
- Role is filled by a senior nurse.

The SILs continue to lead the way with quality improvement across the network, the Trusts commitment to providing them with one day a week to focus on improvement projects must be acknowledged and applauded. A separate 2025/26 report will be published providing more information on the excellent work lead by this group. In 2025 / 26 the Isle of Man SIL has now joined the group which will bring added collaboration going forward. Below shows the details of two projects completed in 2025 / 26 by Warrington & The Walton Centre.

**Cheshire & Merseyside**  
Critical Care Network

**Warrington and Halton**  
Teaching Hospitals  
NHS Foundation Trust

### Patient Diaries & Follow Up Appointments

#### Project Benefits

Potentially shortens recovery time by improving the mental and physical health of ex-patients therefore reducing cost to the NHS.

Gives ex-patients and families access to signposting, support, coping strategies and referral to talking therapies.

Gives opportunity to discuss their ITU stay, physical and mental health, rationalise their thoughts and feelings and what to expect moving forward.

Opportunity to read their patient diary supported by staff.

**Problem statement.**  
Delusional thoughts and lack of post ITU care increases the risk of patients (and sometimes family members) developing symptoms of PTSD, slowing recovery and impairing quality of life. There is also no provision for psychological care post ITU.

**Solution.**  
ITU Follow Up appointments are held monthly for a one-and-a-half-hour duration. They are offered to patients who have been level 3 for three days or more. We talk through what brought them to ITU, what happened whilst they were here, their progress, how they feel and the effects of a critical illness. We also discuss the long recovery time and what to expect moving forward. Information and signposting are available alongside an opportunity to be referred to talking therapies.

**Cheshire & Merseyside**  
Critical Care Network

**The Walton Centre**  
NHS Foundation Trust

### Critical Care Housework Project

#### Project Benefits

It is possible to see exactly what has been done and when, it is obvious at a glance which jobs are due that day.

All housework jobs are completed on time by the correct person. The jobs are not duplicated as they possibly were in the past leading to a time and cost saving.

Unexpected benefits such as it supported compliance in completing the patient diary and ensure hair washing is done twice a week

Provides the opportunity to highlight any problem areas such as the lack of damp dusting. Which is now documented and completed regularly

**Problem statement.**  
Housework jobs being missed or pick up by the Team Leader at the end of the shift as it was not always clear when housework jobs were due. This was because to see what was required you had to look back over a week's worth of charts as it was recorded in the ICU Observations chart.

**Solution.**  
A Senior staff meeting was organised where it was decided that a weekly housework chart would be introduced. This was designed and circulated for comment. It was then implemented, and once staff had time to get used to it, compliance was audited.

#### What this Means

The feedback received from patients and families who accessed the service, its importance is immeasurable. It helps patients and families to come to terms what has happened, support them in recovery, reduce isolation and improve patient journey. Complies with NICE guidance and GPICS. Potentially reduces further costs to the NHS by improving patient recovery time.

*"Implementing a structured Housework Chart on ICU transforms routine tasks into shared responsibility – Promoting accountability, consistency and a safer more organised environment for both patients and staff"*

(Jane Parsons RN - Staff Nurse Horsley ICU)



# Service Improvement Leads Audits

## Spinal Observation Audit

Every year the SILs decide on an audit calendar consisting of topics to audit in aspects of clinical care within critical care. These audits happen three times a year. Once the questions have been agreed the SILs buddy up with another SIL and audit each others Unit. Once the audits are complete the results are analysed and an action plan created. The information below shows the findings of the Spinal Audit completed this year.

### Overview



Audit completed November 2025 at all CMCCN Units.



79 staff responses, average 6 min 14 second completion time.



Purpose of the audit to assess knowledge & confidence in spinal care.

### Key Findings

- Varied experience in Critical Care
- Uncleared and unstable spinal injuries
- Inconsistent spinal device use
- Log-rolling & repositioning issues
- Training gaps & low confidence

### Agreed Actions

- Share spinal care protocol.
- Develop training resources.
- Re-run audit to measure improvement.

### Next Steps

- Standardise spinal care
- Enhance staff training
- Ensure proper alignment
- Repeat audit & review

## Relative Satisfaction Survey

### First Visit Experience

- 94%** Easy to navigate
- 88%** Greeted in 0 – 15 mins
- 78%** Explanation if a delay
- 78%** Prepared for environment

### Communication & Information

- 41%** Written info for next of kin
- 93%** Understood information
- 89%** Spoke with Doctor in private
- 9%** Phone contact issues

### Overall Experience

- 98%** Polite & courteous
- 96%** Privacy & dignity maintained
- 95%** Nurses introduced themselves
- 94%** Updated about condition
- 92%** Listened to concerns

**‘High satisfaction overall, with improvements focused on environment and communication logistics**

### Key Positive Themes

- Compassion & professionalism
- Clear explanations
- Emotional support
- Staff went ‘above & beyond’

### Areas for Improvement

- Privacy curtains
- Buzzer systems
- Waiting times information
- Better next of kin updates

As part of the audit calendar a relative satisfaction survey is run. This year the SILs decided to use Microsoft Forms to collect the data via a QR code. Although there were a good number of completed questionnaires, it was felt that this did reduce engagement with the survey. The plan for 2026 / 27 is to use Microsoft Forms via a QR code but also have hard copies available for relatives to ensure it is assessable for all.

# Local Transfer Service

CMCCN are lucky to have a local transfer vehicle that is facilitated in conjunction with Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH) and Sparks Medical. This service runs daily from 10am to 8pm and is available for all Units to use in transfer of critical care patients within the network and out of region.

This data does not count all the transfers within the network, only the ones that were carried out by the local vehicle.

**132** total transfer from April 2025 to March 2026

**116** transferred in C&M  
**2** transferred in NW  
**10** transferred out of NW

**21** blue light transfers

**12** different transferring hospitals

**13** level 1 patients  
**3** level 2 patients  
**113** level 3 patients\*

**16** different receiving hospitals

**13** transfers in April  
**9** transfers in May  
**6** transfers in June  
**6** transfers in July  
**7** transfers in August  
**6** transfers in September  
**15** transfers in October  
**16** transfers in November  
**12** transfers in December  
**12** transfers in January  
**14** transfers in February  
**13** transfers in March



\*Total transfers with recorded level of care: 129

# Bank & Agency Audit

During 2025 there was a national agreement to change the payment for bank shifts, this was subsequently implemented across Trusts in Cheshire & Merseyside. There has also been a drive to reduce the number of agency staff. These two initiatives were thought to be impacting on staffing rates across the Units in CMCCN. This audit was performed at the request of the senior nurse group as units were experiencing difficulty in filling bank nursing shifts due to the reduction in bank rates across CMCCN Units.

## Participation

8 Units completed the audit:

- Aintree ● Arrowe Park ● Countess of Chester ● Liverpool Heart & Chest ● Royal Liverpool ● Whiston ● Warrington ● Walton Centre

3 Units did not participate, due to:

- No bank system ● Availability of SILs

## Audit Method

- Twice-daily data collection (day and night)
- 2 weeks during July 2025
- Adapted from a piece of work by Greater Manchester Critical Care Network
- Data reviewed by Senior Nurses & SILs
- Data Analysed by CMCCN Lead Nurse

## Audit Fields

- Staff on shift Vs Required
- Unstaffed Beds
- Bank & Agency Shifts
- Loss of Coordinators
- Redeployments
- GPICS Ratios & Delayed Admissions

## Headline Findings

- No elective cancellations
- Reduced bank rate has shown a minimal impact overall
- Reduction in GPICS Compliance
- 3 redeployments
- 2 clinical educators in the numbers
- Loss of Coordinators on a number of shifts.

In addition to the headline findings shown above, anecdotally the Units fed back that it did impact the availability of staffing and staff moral. This impact lasted a number of months.

# Census Overview

During 2025 all Units were required to submit their data to the national adult critical care (ACC) census. The aim is to establish a baseline across the country of ACC services



**Bed Stock & Infrastructure**  
ACC beds decreased to **201**.  
Level 2 down **5%**, surge bed **16%**

It also supports planning of services at local, network, regional and national level. All data from the census is analysed and published on a dashboard within the NCDR portal.



**Registered Nurse Workforce**  
4.81 WTE RNs per bed.  
High % of Band 7 Nurses



**Pharmacy & AHPs**  
Gaps within pharmacy and AHP workforce. Rehabilitation mostly only **Mon - Fri**



It helps to understand changes to adult critical care capacity and workforce. It is a biannual audit to understand how capacity and establishment of critical care service delivery is evolving.



**Vacancies & Sickness**  
Vacancies **improving**  
Sickness **6.5% is above** national average



**Psychology Support**  
A number of units still **lack** psychology provision



**Education & Training**  
**1 Educator** per 75 staff minimum.  
**50%** of RNs with post registration award



**Outreach Teams**  
Highest number of Band 6 in the Northwest  
**Inconsistent 24/7** cover

The results are broken down into nationally, regionally, and local level.



**Medical Staffing**  
There are **118** Speciality Doctors & **71** Consultant across the Network



**Support Staff**  
**All** have Ward Clerks apart from one Trust



Access to critical care data has improved in 2025 /26 but as a network we are still not where we want to be despite there being a large amount of critical care data collected nationally. As with all data it is only as good as the information that is submitted.

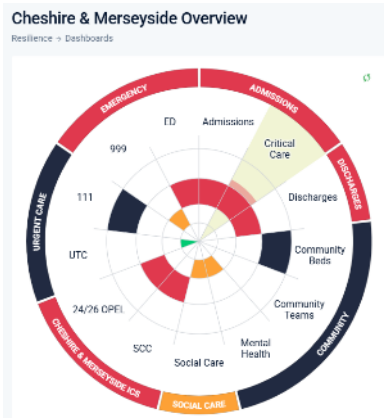
The national data that is available falls into three main sources:

- Directory of Service (DOS); twice daily submission by Trusts focusing on bed capacity and staffing.
- Intensive Care National Audit & Research Centre (ICNARC) case mix programme which looks at patient outcomes and is submitted monthly.
- The Critical Care Minimum Data Set (CCMDS) includes a total of 34 data items related to periods of care in adult critical care units. Among these, 14 items are mandatory for submission. The data collected typically includes: Admission and discharge methods, sources, and location, clinical details such as diagnoses and treatments provided during critical care.
- National Commissioning Data Repository (NCDR) which takes data from DOS and CCMDS and presents it to be used for commissioning.



In 2024 / 25 the three Northwest (NW) CC networks started a project looking at pulling the wide range of CC data into one front end dashboard. Further funding was approved through 2025 / 26 to continue work on this important project.

The CMCCN have worked with ICB colleagues to ensure that data is populating the regional SHREWD tool correctly, giving regional oversight of critical care capacity.

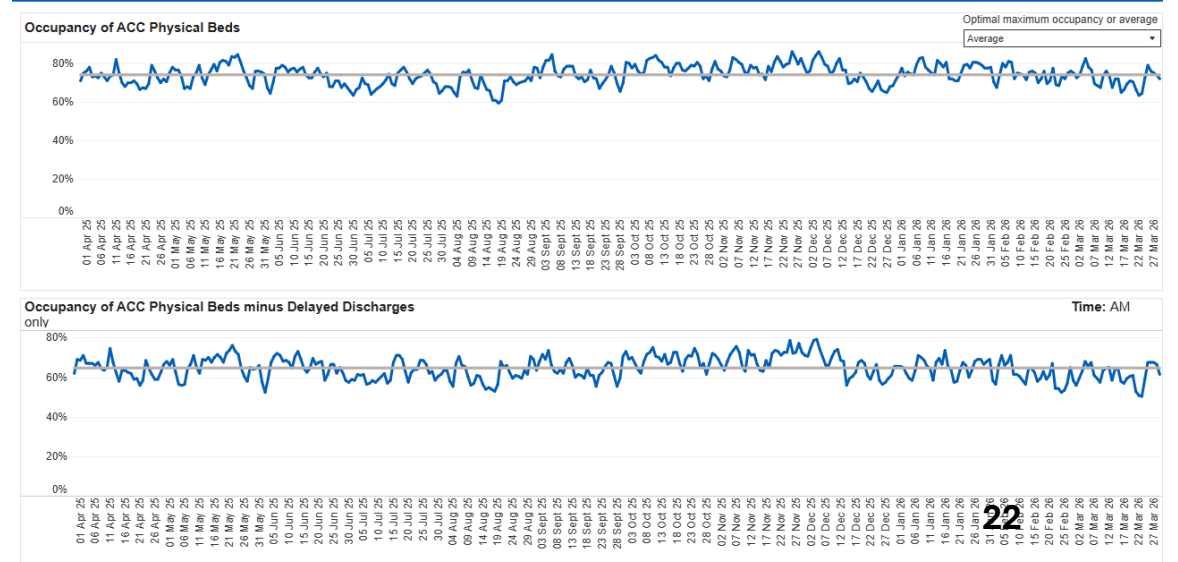


CCN	Countess of Chester	Maccfield B&H	Royal Liverpool	Alintree	Leighton	Southport	Whiston	Warrington	Arrowe Park	Walton Centre	Liverpool Heart & Chest
CRTCON Status	0	0	0	0	0	0	0	0	1	0	0
Critical Care Beds Available	0	1	7	5	5	1	5	2	2	1	1
Committed Critical Care Beds	0	0	0	0	0	0	0	0	0	1	1
Delayed Discharges	1	0	9	5	3	2	4	7	1	1	0
Total Occupied Beds	15	3	26	18	6	12	9	15	11	15	18
Bed Occupancy %	100%	50%	78.79%	59.23%	54.55%	80%	64.29%	68.36%	61.11%	83.33%	60%

During 2025 / 26 CMCCN went live with their collaborative dashboard, there are 29 different pages showing different charts in the new dashboard.

1. Beds, Patients and Competent Nurses High Level Overview
2. Beds Compared to ACC Competent Nurses
3. Percentage of Patients in Funded Baseline Beds
4. Proportion of Patients
5. Total Patients Vs Total Patients Minus Delayed Discharges
6. Occupancy of ACC Physical Beds
7. Occupancy: Committed Beds Vs Staff Beds at 8am
8. Occupancy: Committed Beds
9. Occupancy
10. Staff Vs Additional Physical Beds
11. Proportion of Patients in Staffed Beds
12. Total Patients (All Levels)
13. Staff Beds
14. Admission to Discharge Flow
15. GPICS Compliant
16. CC Admission to CC Discharge Flow
17. Admitted Treatment Function Code
18. Admission
19. Admission KPIs
20. Discharge KPIs
21. CC Discharges
22. CC Discharge Location
23. CC Discharge Status
24. Death
25. Data Quality
26. Count of Patients CCMDS Vs DOS
27. Occupancy in CCMDS Vs DOS
28. Health Inequalities
29. Geographical Map

## Occupancy of ACC Physical Beds





## Workforce

- If Units are unable to meet the staffing levels determined by GPICS then patient care may be compromised.
- If there continues to be changes in the availability and structure of training programmes for medical staff, then this may impact on both the capacity and capability to support CMCCN unit rotas.

## Contributing Factors

- Recruitment
- Retention
- Vacancy freezes
- Changes to staff bank
- Reduction in use of agency
- GPICS v3
- Number of Junior Medical Staff
- Training places



## Education

- If Staff are unable to complete the relevant training then patient care may be compromised.



## Patient Engagement

- The patient and public voice will not be sufficiently captured to inform changes led by the Networks which may mean changes do not represent what is needed.

## Contributing Factors

- Removal of national funding
- Local financial challenges
- Educators being in the numbers



## Operational

- If Units are discharging patients directly home then patients may not be receiving the level of care or follow up care appropriate.
- There may not be the appropriate level critical care bed available when needed which may delay admission for elective or non-elective patients & impact on their care.

## Contributing Factors

- Pressures in patient flow
- Staffing
- Flow through hospital
- Winter pressures



## Service Change

- Plans for local or regional service changes may not factor in appropriate critical care provision which may impact patient care.



## Transfers

- If a patient transfer is not undertaken in line with agreed network protocols then patient care may be compromised.

## Contributing Factors

- Removal of NHSE
- Changes in ICS

## Contributing Factors

- North West Transfer Service procurement
- Lack of local guidance



## Spinal

- Due to demand at the North West Regional Spinal Injuries Centre (NWRNIC) the major trauma pathway and patient care may be compromised for patients with traumatic spinal cord injury (tSCI) .
- The lack of capacity at the NWRNIC impacts on critical care capacity and could compromise patient care.

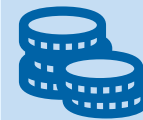
## Contributing Factors

- Commissioning changes.
- Training issues for Trusts who receive repats.
- Complexity of patients.
- C&M largest referrer.
- System pressures e.g. capacity at MTCC sites
- Patients being repatriated to CC units



## NHSE Reorganisation

- The large scale changes to the NHS will impact on NHSE, Specialised Commissioning and the future of Networks.



## Network Funding

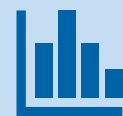
- If there is a reduction in the allocation of funding for the Networks, then roles within the team will not be fully funded.

## Contributing Factors

- Available funding
- Strategy changes in the NHS

## Contributing Factors

- Current financial challenge
- Pay awards increases
- Increment increases



## Data

- If Units/Trusts do not submit the required data submissions in a timely manner, then the true position of services may not be depicted on local and national dashboards which may lead to poor service provision.
- That it may not be possible to analyse and benchmark performance or quality to support any network lead changes or future development of services at individual unit or wider regional level because the Networks are unable to access timely and accurate data and information from Trusts.

## Contributing Factors

- Digital Systems
- Staffing
- Funding

# Network Challenges



## Delayed Step Downs / Discharges

The biggest challenge for Units in CMCCN are delayed step downs / discharges. Caused by persistently high hospital occupancy, stagnated flow through hospital wards including the emergency department, resulting in reduced capacity for ward step downs from critical care. However, positively, looking at the data this does not appear to be delaying admission to the Units.

## Estate

In several Units in CMCCN their estate is a challenge. This can be down to the size, layout and age. In some cases, mixed sex accommodation is still not achieved. As part of the peer review process Units are advised to include this on their risk registers. With the current financial pressures in the NHS a solution to these challenges does not seem viable in the short term.

## Workforce

All critical care professions are experiencing some challenges. The Peer Reviews identified many gaps in AHP, Psychology and Pharmacy, which have been included in Trust risk registers and monitored. Nursing recruitment and retention remains a challenging area, as does the recruitment of medical staff in some Trusts.



## Data

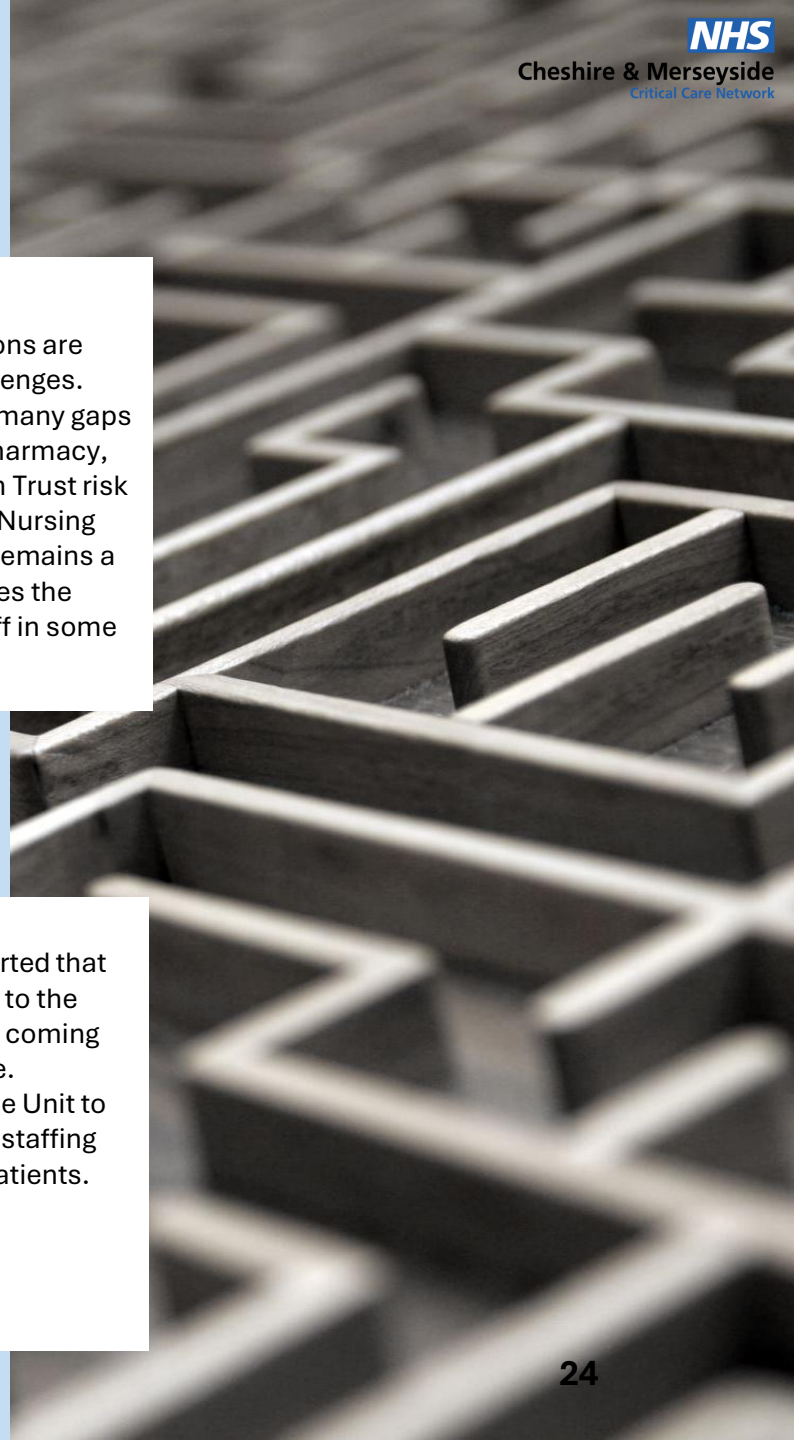
Critical care data remains a challenge for CMCCN. Although as discussed in this report there is a wide range of CC data available not all of it is accurate and useful. Progress has been made with the NW Critical Care dashboard but it is felt there is still a way to go before data can be properly interrogated through Network governance.

## Capacity

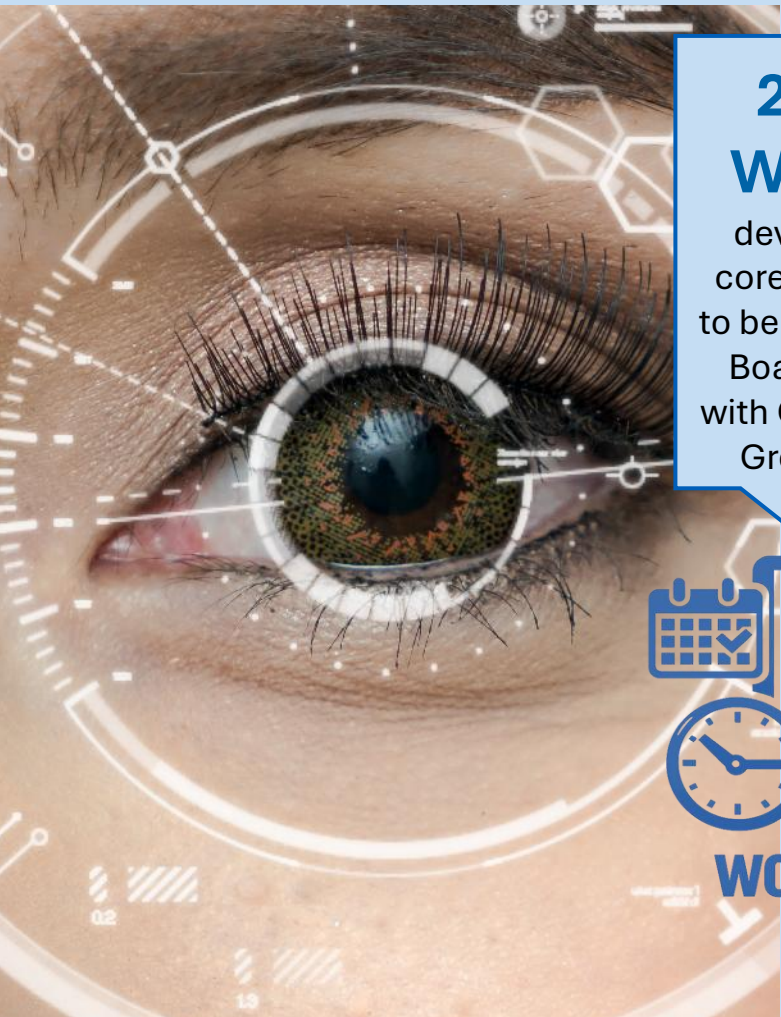
Capacity within the CMCCN central team remains a big challenge for the delivery against the national service specification. 2025/26 has been particularly challenging with long term sickness within the team.

## Patient Acuity

Nationally it has been reported that there has been a change to the 'normal' acuity of patients coming through critical care. This has put pressure on the Unit to ensure they have the right staffing model to support these patients.



# Looking Forward to 2026 / 27



**2026/27 Workplan**  
developed by the core network team, to be ratified at SSCN Board and shared with CMCCN Clinical Group Members



## WORK PLAN



## KEY DELIVERABLES

**24 Key Deliverables identified**  
covering all seven of the core network functions defined by NHS England

**110 Key Milestones identified**  
Progress against each milestone will be monitored and reported



## KEY MILESTONES



## IMPACT & BENEFITS

Each deliverable has **multiple impacts and benefits identified**, covering all aspects of Critical Care Services.

### Key Projects 2026 / 27

- Maintain transfer services that are safe, robust, and clinically appropriate
- Deploy and embed the Mela solution to support operational oversight and day-to-day service delivery across the network
- Ensure compliance with data submissions at Network, Regional and National Level.
- Supporting Clinical Leadership through the establishment of a Medical Leads Working Group
- Understand the current / baseline compliance against GPICS 3 for staff.
- Have a continued focus on quality improvement across the network.
- Interim peer review process to be undertaken across the network.
- Use the data collected in the 2025 / 26 census to support service delivery
- Ensure that the Network Clinical Governance process is fit for purpose and lessons learnt are shared.
- Develop working group to draft guidance on the appropriate nursing dependency for the level of care of the patients



**CHESHIRE & MERSEY**  
**ADULT CRITICAL  
CARE NETWORK**

**Annual Report 2025 – 2026**

This Annual Report has been produced by the ***Cheshire & Mersey Major Critical Care Network***, part of the ***Cheshire & Mersey Specialised Services Clinical Networks for Adult Critical Care and Major Trauma*** .

If you require further information or detail in relation to any aspect of this report, please contact: [wcft.cmodn@nhs.net](mailto:wcft.cmodn@nhs.net)

