Wirral University Teaching Hospital

Quality Account

2020-2021

Part 1: Foreword

Reflecting on the past 12 months, I have enormous pride and admiration for our staff and volunteers, who continued to deliver high quality and safe care to patients and their loved ones, throughout the COVID19 pandemic. Our staffs professionalism, resilience and flexibility have been truly inspirational and our volunteers have been there with us throughout the past year, proving their commitment and selflessness; they continue to be invaluable.

The support, care and treatment of patients suffering with COVID-19, along with protecting our staff were our primary aim throughout the past year, whilst also maintaining cancer and urgent care services.

The Trust continues to pursue excellence in the care and treatment we provide and despite the significant pressures over the past twelve months we have continue to progress , delivering our new Trust Strategy and vision. We have also progressed in a number areas outlined within our 3 year Quality Strategy, published in 2019/20.

Recovery following the pandemic is an area of continued focus with an aim to reduce the waiting times for patients requiring elective care.

We have recently launched the Trust's Improvement Approach and have identified a number of areas for focused quality improvement: Improving the early recognition, escalation and response to deteriorating patients, falls prevention, tissue viability, nutrition and hydration. This builds on the work undertaken previously to develop improvement skills within the organisation, as we embed improvement within our culture.

In addition we have agreed a twelve month programme to review and strengthen our approach to patient safety in line with the aspirations within the recently refreshed National Patient Safety Strategy.

We underwent a focused CQC inspection in February 2021, relating to Infection Prevention and Control, which found no significant concerns and reported on the significant progress and improvement made within the organisation over the past year.

Finally I am pleased to confirm that the Board of Directors has reviewed the 2020/21 Quality Account and can confirm that it is an accurate and fair reflection of our performance.

Janelle Holmes
Chief Executive Officer

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2.1 (a) Priorities

Trust Response to COVID-19

In early March 2020, in response to the spread of the COVID-19 virus across the world, the NHS declared a Level 4 incident and all providers were placed in a "command and control" environment, with all activity being directed from the NHS England/Improvement Incident Management Team.

At Trust level, we established our incident command structures to co-ordinate the response to the pandemic and oversee all daily functions. This resulted in the centralisation of governance, the development and delivery of a COVID clinical model, the reconfiguration of wards and beds, and the expansion of staff wellbeing systems. In addition we saw the reduction of elective surgery and transformation of outpatients.

The changes to practice and ways of working over the past twelve months have demonstrated the adaptability, flexibility and commitment of our staff in the pursuit of maintaining high quality care. A small number of the many initiatives and changes that we undertook in order to respond to the pandemic are outlined below:

- Rapid adaptations to the clinical model were implemented to provide a suitable environment; suited to meet the needs of patients and to maintain staff safety when providing direct patient care.
- An adapted medical staffing model was introduced for the wards leading to additional Consultant presence on each ward, every day.
- The Emergency Department (ED) layout was split into COVID-19 and Non-COVID-19 areas and the minor injuries unit was relocated to the fracture clinic site, in the outpatients department for all Non-COVID-19 minor injuries.
- A "Respiratory Receiving Unit (RRU)" outside of the ED footprint was created to fast-track patients clinically suspected as having COVID-19 infection.
- Extensive physical modifications across the Trust clinical footprint and waiting rooms were undertaken to ensure social distancing and provide increased Infection Prevention and Control measures.
- A Critical Care surge plan was produced to provide capacity from the unit's capacity of 18 beds up to 42 beds. This was achieved by the expansion of the unit into the main theatre complex, as well as recovery and ophthalmic theatres. Staff members were upskilled from theatre environment to provide care in the event of surge and redeployment to the core critical care beds.
- An urgent and emergency surgery service was maintained through designated theatres and Wards.
- Diagnostic services were maintained to support ED, Inpatients, cancer and clinical urgencies.
- The Pharmacy workforce was remodelled to support key areas of demand both within the Trust but also across the Primary Care Networks to maintain patient safety. Staff members were deployed across the system to the point of greatest need at critical points in the pandemic.
- Medicines e-learning was developed for all clinical staff that required upskilling in the use of critical care, respiratory renal and palliative care medicines.
- Family Support Team was established to maintain contact between families and inpatients throughout the pandemic, when visiting was restricted.
- Within Maternity Services the Trust supported birth partners to attend labour and through the postnatal period on the ward, including the opportunity to stay throughout and we continued to offer all four birth places: Home, Free-standing at Seacombe, Midwifery Led Unit and Labour Ward.
- The Microbiology service processed >200,000 COVID-19 PCR samples received since the beginning of the pandemic. This was in response to a rapid requirement for high volumes of

timely COVID-19 tests for patients and staff, to support patient treatment as well as staff and patient isolation and patient flow.

- Effective monitoring and surveillance was established in order to understand COVID-19 transmission within the hospital, providing transparency on performance and supporting a focus on continuous improvement.
- The Clatterbridge Vaccination Centre opened on the 8th December 2020 and worked closely with GPs within the local Primary Care Networks and other secondary and tertiary care organisations across the system to ensure that our local population was vaccinated at the earliest opportunity.
- Plans for restart and recovery were developed from July 2020 and are well underway
- Nursing staff across the Trust were supported with additional training to enhance skills and knowledge of respiratory care/ DONNING and DOFFING and the management and care of patients with COVID-19.
- The Trust established a FIT Testing team, undertaking 20880 tests across 4560 staff, during the pandemic to enable staff to have access to FFP3 masks in line with the changing supply of products available.

Quality Strategy

In May 2019, the Trust launched its 3 year Quality Strategy. This set out four key campaigns, each with a set of over-arching goals and a number of key outcomes. This provided a road map, to ensuring patient-focused high quality care. Year 1 of the Quality Strategy (2019/20) focussed on establishing systems to ensure effective measurement, and establishing baselines to enable structured improvement work to commence in Year 2 (2020-21). Progress has been recently reported through the Trust's Patient Safety and Quality Board and through to the Quality Assurance Committee. Due to COVID-19 pandemic and associated pressures within the NHS, much of the improvement work planned was paused during the year. Reporting has continued, where possible, to ensure continuity and to ensure plans have been maintained as part of the Trust's recovery post COVID-19.

The below measures set out key Trust wide quality targets, which were our priorities for 2020/21:

	Target	Achieved during 2020/21	Progress during COVID
A Positive Patient Experience			
Friends & Family Test recommend rate: inpatients	≥95%	*Dec 20 – Mar 21* 94%	On hold from March 2020- November 2020
Friends & Family Test recommend rate: outpatients	≥95%	*Dec 20 – Mar 21* 95%	On hold from March 2020- November 2020
Care is Progressively Safer			
Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	≤0.24 per 1000 Bed Days	0.16	A revised Falls tracker has been developed to incorporate additional review indicators from learning outcomes, in addition the preparation form has been changed to streamline the review and make the process more efficient. Weekly themed review is undertaken of falls with targeted actions developed, based on review.
Reducing hospital acquired infections - Hospital Acquired Clostridium difficile	≤88	62	The Trust were noted to have areas of outstanding practice for the CQC focused inspection for Infection Prevention which took place in Feb 2021 and published in April 2021. The Trust has remained under trajectory for all Gram Negative KPIs with the exception of MRSA bacteremia. There have been 2 cases of MRSA in 2020/2021
Reducing hospital acquired infections -Hospital Acquired MRSA	Zero tolerance	2	

Pressure Ulcers - Hospital Acquired Category 3 and above	Zero tolerance	10	Increase in assessments carried out in the emergency department and increase in number of incident forms identifying pressure ulcer damage on admission to the Trust. Risk assessment and care planning is monitored via the Harms audit. Tissue Viability has been agreed in April 2021 to be an area of QI coaching focus. The Trust has appointed a TV lead Nurse who has revised work plan of focused improvements for 2021/22.
Nutrition and Hydration - MUST completed at 7 days	≥95%	96.7%	The Nutrition and Hydration group oversees the workplan and ensures progress against the key priorities. Developments are underway to enable effective compliance reporting utilising automated reports from Cerner , perfect ward and the BI portal .Fluid balance is also a key area of focus in the a QI collaborative project for Deteriorating patients
Nutrition and Hydration - MUST completed within 24 hours of admission	≥95%	96.6%	
Care is Clinically Effective and Highly Reliable			
Mortality Review: Avoidable factors associated with mortality	≤2%	1.22%	Medical examiners currently escalate deaths to the mortality review group for further investigation. Cases are categorised into a number of groups, including family / carer concerns, death following elective admission, deaths in patients with learning difficulties, identified wider learning for system improvement and where there were significant concerns on the quality of care.

In line with the national recommendation as part of the response to the pandemic, Friends and Family testing was suspended for the majority of 2020. Small sample testing commenced in December 2020, along with technology solutions to collate voice clips, text messages and emails. Feedback is being given to teams in Feedback Friday's, highlighting key messages from patients and families. Core values posters have also been created for each area, to feedback to patients and families actions taken as a result of the feedback received.

The Trust achieved a 35% (32) overall improvement for Gram Negative Infections compared to 2019/2020 and has reported 62 *Clostridium difficile* infections. This is a reduction of 30% (27) when compared to 2019/2020, 26 cases under the cumulative trajectory for 2020/21. The Trust did report 2 MRSA bacteraemia cases, 1 case more than the previous year. A full review of cases has been undertaken at the Executive Director of Infection Prevention and Control Meeting to establish learning and ensure key actions are taken to prevent future occurrences.

The Trust has undertaken a significant amount of work to reduce the prevalence of Hospital Acquired Pressure Ulcers. Following investment into the team, to appoint a Lead Nurse for Tissue Viability and an expansion of the clinical Tissue Viability Team, significant focus has been made to raise the profile of Tissue Viability across the Trust. Over 200 senior nurses have undertaken specialist Tissue Viability Training and are supporting the validation and management of wounds across the Trust. The Trust also saw the launch of the SSKIN prevention campaign in 2020 and the establishment of the Tissue Viability Link Nurses across the Trust. As a result the Trust has seen a reduction of all categories of Hospital Acquired Pressure Ulcers in 2020/21.

2.1 (b) Looking forward to 2021-22. What our priorities are, and how we are planning to achieve on these.

Quality Improvement

The Trust has established a Quality Improvement (QI) Team and developed a Trust Improvement Approach. The QI team has undertaken and facilitated significant engagement work with clinicians and stakeholders to identify and agree the following Quality Improvement Priorities and Programmes for the Year 2021-22:

Breakthrough Quality Improvement Priority: Deteriorating Patients

Quality Improvement Programmes: Falls, Infection Prevention and Control, Tissue Viability and Nutrition and Hydration.

The areas above were identified following data analysis of trends from the Business Intelligence (BI) Portal and Perfect Ward, as well as CLIPPE Reports (Complaints, Litigation, Incidents, Patient Advice and Liaison Service and Patient Experience) and Care Quality Commission (CQC) Action Plans. Faculties / Steering Groups are being established to identify the wards to be involved, based on robust data analysis.

The QI team will utilise both the Breakthrough Series Collaborative, and QI Coaching approaches to support improvement. In addition, intermediate QI training will be provided to the Deteriorating Patients Faculty, once established and participating Wards.

An Improvement Lead is assigned to each QI Programme to provide QI coaching, access to resources and data analysis to track improvements. Structured methodology will be followed with standardised tools, templates and documentation. Improvement Huddles will be implemented using new ward Improvement Boards, with training and initial facilitation to support effective use.

Deteriorating Patients: The aim is to improve the early recognition, escalation and response to deteriorating patients.

Compliance in recording National Early Warning Score (NEWS) 1-4 remains below the Trust and Perfect Ward targets of 95% and 90% respectively. Recording of NEWS 5-6 and NEWS within 30 minutes is also below the Trust target of 95%, and the numbers of Medical Emergency Team (MET) calls have increased. Acutely unwell patients can deteriorate at any point in their illness or care pathway and therefore early identification of this can reduce risks to patient safety.

Sepsis Screen remains below target. This will continue to be managed via the AQUA Advancing Quality (AQ) Programme, but linked into the collaborative and data monitored.

Compliance in the recording of fluid balance remains low across the Trust, due to variation in recording and interpretation across specialities and clinical indications.

Falls: Aim is to continue to focus on preventing and managing falls in areas where falls cause harm.

Despite significant improvements, there had been an increase in falls and unwitnessed falls on a number of wards over the first 3 months of 2021. Although this has subsequently reduced, it has been agreed to adopt a structured QI approach to assess the current state and root causes and to target, plan and test changes to make improvements, via PDSAs (Plan, Do, Study, Act), across wards where data indicates high prevalence (localised falls improvement).

Nutrition: Aim is to continue improve the screening and recording of nutritional status and implement the right nutritional care bundles to meet them.

Significant improvement work has been completed in relation to (Malnutrition Universal Screening Tool) MUST assessments. However, as we move to a further focus on quality, elements including completion of food charts and hospital acquired weight loss require a formalised QI and monitoring process. Nutrition is a fundamental element of patient care and impacts on patients' recovery, length of stay, skin integrity and rehabilitation. QI Coaching will be offered to the existing Steering Group, to develop an improvement plan with clear aims, measures and changing ideas to test and monitor impact.

Infection prevention and Control (IPC): Aim is to continue to take proactive action to avoid all hospital acquired infections.

Significant improvement work has already resulted in a reduction in infections over the past twelve months however this improvement needs to be sustained by embedding IPC in everything we do. There will be a continued focus on IPC visual management and implementation of "every action counts". QI Coaching will be offered to develop an improvement plan with clear aims, measures and changing ideas to test and monitor impact.

Tissue Viability: Aim is to reduce the numbers of patients who develop hospital acquired pressure ulcers.

Despite improvement, there is some local variation which would benefit from targeted work to support focus on improved education and preventative measures including top to toe assessments and wound measurements, descriptions and management. QI Coaching will be offered to develop an improvement plan with clear aims, measures and changing ideas to test and monitor impact.

The above programme will have an Executive Sponsor and a Clinical Lead, with progress being reported through the Patient Safety and Quality Board.

Patient Safety

A twelve month programme to support further development in developing a safety culture, strengthening our patients safety intelligence and ensuring staff and patient involvement has been agreed and is in the early stages of development, the keys components and aims are outlined below:

Safety Culture:

- Undertake work relating to how the organisation measures safety culture
- Develop and embed further a Just Culture by adopting the NHS Just Culture Guide
- Further embed the principles of a safety culture within the organisation

Patient Safety Insight:

- Develop further how we consider the current intelligence (from complaints, claims, incident reporting, patient and staff feedback, clinical audit, mortality reviews) we have and how we use it to inform and plan our safety improvement work in the future.
- Build capacity to identify emerging/actual safety themes and good practice areas
- Build capability in incident/safety investigations to ensure the staff and patient voice is heard and that we adopt a systems approach.
- Develop further how we listen and engage with patient facing staff when designing and testing improvement plans
- Review how we monitor improvement plans for effectiveness to ensure we deliver the change we want to see.
- Support the implementation of the PSIMS (Patient Safety Incident Management System), which will replace the current National Reporting and Learning system (NRLS) and StEIS.

- Review our internal process for managing and assuring compliance with Patient Safety Alerts
- Consider how we utilise the output of our work to inform the forward plan for clinical audit to support evidence of sustained improvement

Patient Safety Involvement

- Implement the National Framework for Involving Patients in Patient Safety within the Trust once finalised

Recovery of Elective Care Post COVID-19

The Trust has a developed programme of work to reduce the waiting times for elective procedures, which is underway.

2.2 Statements of Assurance

During 2020/2021 Wirral University Teaching Hospitals NHS Foundation Trust provided and/or subcontracted the 82 relevant health services

Wirral University Teaching Hospitals NHS Foundation Trust has reviewed all data available to them on the quality of care in all 82 of these relevant health services.

The income generated by the relevant health services reviewed in 2020/2021 represents 100% of the total income generated from the provision of relevant Health Services by The Trust for 2020/2021

2.3 National Audits

During 2020/2021, 43 national clinical audits and 1 National Confidential Enquiry (NCEPOD) covered relevant health services that the Trust provides. We participated in 60% of the national clinical audits due to either suspension of the remaining audits, or the impact of pressures arising from the COVID-19 pandemic within the Trust. The National Confidential Enquiry Programme was suspended for the year due to COVID-19 pressures.

The national clinical audits and national confidential enquiries that Wirral University Teaching Hospitals NHS Foundation Trust participated in, and for which the data collection was completed during 2020/2021 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit	**Case % of Submission**
Antenatal and newborn national audit	Data not collected due to COVID pressures
British Association of Urological Surgeons (BAUS) Urology Audit - Cystectomy	Continuous data Monitoring
British Association of Urological Surgeons (BAUS) Urology Audit - Nephrectomy	Data not collected; this audit has been stood down by BAUS
British Association of Urological Surgeons (BAUS) Urology Audit - Percutaneous Nephrolithotomy	Data not collected; this audit has been stood down by BAUS
British Association of Urological Surgeons (BAUS) Urology Audit - Radical Prostatectomy	Continuous data Monitoring
Case Mix Programme (CMP)	Continuous data Monitoring
Child Health Clinical Outcome Review Programme (NCEPOD)	Data not collected due to COVID pressures
Elective Surgery (National PROMs Programme)	Continuous data Monitoring

Royal College of Emergency Medicine (RCEM) - Assessing Cognitive Impairment in Older People	164 (100%)
RCEM - Care of Children	261 (100%)
RCEM - Mental Health	127 (100%)
Falls and Fragility Fracture Audit Programme	12 (100%)
Inflammatory Bowel Disease (IBD) Audit	Data not collected due to COVID pressures
Learning Disabilities Mortality Review	Continuous data Monitoring
Maternal and Newborn Infant Clinical Outcome Review Programme	Continuous data Monitoring
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Data not collected due to COVID pressures
National Audit of Breast Cancer in Older Patients (NABCOP)	Continuous data Monitoring
National Audit of Care at the End of Life (NACEL)	Suspended in 2020 due to COVID pressures. Due to recommence in 2021-22
National Audit of Dementia (NAD)	Data not collected due to COVID pressures
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Continuous data Monitoring
National Cardiac Audit Programme (NCAP): Cardiac Rhythm Management MINAP Heart Failure	Data not collected due to COVID pressures
National Diabetes Audit	Data not collected due to COVID pressures
National Early Inflammatory Arthritis Audit (NEIAA)	715 (100%)
National Emergency Laparotomy Audit (NELA)	Continuous data Monitoring
National Gastro-intestinal Cancer Programme (NBoCA)	Continuous data Monitoring
National Joint Registry	Continuous data Monitoring
National Lung Cancer Audit (NLCA)	Continuous data Monitoring
National Maternity and Perinatal Audit	Data not collected due to COVID pressures
National Neonatal Audit Programme (NNAP)	Continuous data Monitoring
National Ophthalmology Database Audit	Continuous data Monitoring
National Paediatric Diabetes Audit (NPDA)	Continuous data Monitoring
National Prostate Cancer Audit (NPCA)	Continuous data Monitoring
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	NCEPOD Programme has been on hold throughout 2020-21 due to COVID pressures
Perioperative Quality Improvement Programme (PQIP)	Data not collected due to COVID pressures
Sentinel Stroke National Audit Programme (SSNAP)	Case ascertation category A (88% +)

Serious Hazards of Transfusion Scheme (SHOT)	Data not collected due to COVID pressures
Society for Acute Medicine Benchmarking Audit (SAMBA)	70 (100%)
The Trauma Audit & Research Network (TARN)	405 submitted
UK Cystic Fibrosis Registry	36
UK Registry of Endocrine and Thyroid Surgery	Data not collected due to COVID pressures
UK Renal Registry National Acute Kidney Injury Programme	Continuous data Monitoring

The reports of 11 national clinical audits were reviewed by the provider in 2020/21 and Wirral University Teaching Hospitals intends to take the following actions to improve the quality of healthcare provided. Remaining reports published within year are due for review at the relevant Divisional Quality Boards in the first quarter of 2020/21; the reason for these delays has been limited capacity, due to pressures arising from the COVID-19 Pandemic.

Audit	Outcomes /Action
Case Mix Programme (CMP)	The unit has consistently low numbers of reported unit-acquired blood infections compared to other similar units. A positive reduction has been noted in both delayed ward discharges post 24 hours and out of hours discharges to the ward; though it must be noted that the results from the case mix programme during 2020/21 have been impacted by COVID-19. This is in part due to the nature and characteristics of the presenting patient illness, along with changes to the management of patient flow at this time. It is therefore difficult to compare to previous year's results or identify meaningful areas for focus for the year ahead. However, risk adjusted acute mortality figures do remain similar to other comparable units.
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	**Key Successes** • A full dataset has been achieved due to the dedication of the specialist nurse, a significant proportion of Trusts have not engaged with the audit at all due to time constraints. **Key Actions** • A Power form on Cerner Millennium for epilepsy patients is currently in the early stages of development. *(local action)* • A novel screening questionnaire is under development for piloting *(local action)*
NCAP - Cardiac Rhythm Management	**Key Successes** • A second device procedure within 12 months is good; 4% pacemakers 6% complex devices. Catheter ablation re-intervention rates are low by international standards 18% within 2 years following ablation for atrial fibrillation suggesting good case selection and effective procedures **Key concerns** • There is considerable variation in re-intervention rates between hospitals which may reflect high complication rates at some **Key Actions** • GMC numbers must be submitted by hospital as large numbers of low volume implanting and ablating consultants. Hospitals must increase documentation for compliance against NICE guidelines for pacemakers and ICD's. Clinical data submission field entries remain inadequate but improving. *(National action)*
NCAP - MINAP	**Key Successes** • The proportion of patients with ST-Elevation Myocardial Infarction (STEMI) who receive immediate reperfusion treatment has increased to the highest recorded level. Primary Percutaneous Coronary intervention (PPCI) is the default reperfusion treatment throughout the participating nations - rates of PPCI in Wales are now as high as in England and Northern Ireland. Performance of an echocardiogram following STEMI is at its highest recorded level. There is a high level of involvement of cardiologists in the management of patients with non-ST-Elevation Myocardial Infarction (NSTEMI). The proportion of eligible patients undergoing a coronary angiogram following NSTEMI has increased to its highest ever level. There is consistently good performance in the prescription of drugs to prevent subsequent heart attacks (secondary prevention) at the time of discharge from hospital. A previously reported deterioration in rates of referral to cardiac rehabilitation programmes following heart attack has reversed. There is a continuing trend towards less recorded proportion of patients treated within the standard 'Call To Balloon' interval (CTB); this appears to relate to increasing pre-hospital delays. There has been little improvement in the proportion of patients with NSTEMI undergoing coronary angiography within the NICE Quality Standard of 72 hours after admission to hospital. **Key Concerns** • There has been little improvement in the proportion of patients with NSTEMI undergoing coronary angiography within the NICE Quality Standard of 72 hours after admission to hospital

	Key Actions • Concerning admission to a cardiac ward, where possible, patients with a heart attack (both STEMI and NSTEMI) should be treated on a cardiac ward, but outreach services should be provided for those nursed elsewhere. Those hospitals not reaching recommended levels should review their systems and bed allocations to allow patients the benefits of access to cardiac care. *(National action)*
NCAP - Heart Failure	**Key Successes** • 1-year mortality has improved but is significantly lower for those having cardiology follow-up, heart failure (HF) nurse input, and cardiac rehabilitation. 1-year mortality rates for HFrEF continue to be substantially lower for those discharged on all three disease-modifying drugs. **Key concerns** • In-patient mortality has improved, but it is still lower for those admitted to cardiology wards and for those who access specialist care. Application of the gold standard diagnostic test, echocardiography, remains acceptable but the inter-hospital and ward-based variation, while it has improved slightly, needs further improvement. The proportion of patients admitted to cardiology wards is static at <50% and leaves scope for improvement in many hospitals. In-patient mortality has improved, but it is still lower for those admitted to cardiology wards and for those who access specialist care. **Key Actions** • Hospitals should ensure that high-risk cardiac patients have access to cardiology wards. Further research is required into the association between length of stay, severity of disease and outcomes, especially around the value of short periods of hospitalisation for initiation of care supported by community service *(National action)*
National Emergency Laparotomy Audit (NELA)	**Key Successes** • Increased compliance with the key standards set out by the National Audit. Mortality remains below the national average, Trust death rate 7.3% (7.1% in 2018) compared to national rate of 9.3%. The compliance against key processes has increased, building on previous successes (consultant delivered operating care and timeliness to surgery once decision made to operate) A green RAG rating (> 85% compliance) has been achieved in the domains of pre-operative risk assessment and critical care admission for the highest risk patients (calculated mortality risk >5%) for the first time since the audit began. There have also been improvements in the proportion of high risk cases having consultants involved in pre-operative decision making pre surgery including review by intensive care, although still some work to do in the latter category, however this improvement is likely due to the increase in multidisciplinary team (MDT) decision making that has developed as the push to increase admissions has been made. There has been a big increase in the proportion of elderly patients being reviewed by Care Of The Elderly (COTE) specialists, increasing from 11 to 67% in one year due to the introduction of COTE reviews **Key Concerns** • On national indicators the Trust is not green compliant with regards consultant radiologist reviewing at CT scans pre surgery, although this may be in part due to inaccurate reporting (e.g. clinicians unaware that 4 ways are all consultants), but also, that service structure (using HUB), has registrar reports. The Trust also has a >5% discrepancy rate between CT reports and actual operative findings raising the possibility of a quality service issue. Nationally, sepsis management of these patients is sub optimal, and anecdotally, there is room to improve this locally also. Although timeliness to surgery once decision to operate is made is within expected standards, improvements could be made in recognition of patients in need of surgery and sepsis / source control management faster. Lastly, there is inadequate resource allocated to COTE service reviews. **Key Actions** • Build on current progress with ITU involvement in pre-operative reviews, decision to operate and post-operative support. Facilitate earlier recognition of the sickest and highest risk patients through to expedite time from admission to surgery. This will need the reintroduction of an emergency laparotomy pathway, but also staff education in admitting specialities and patient receiving areas like SEU on criteria that identify the highest risk patients, and guidelines to ensure no delays to operating theatre access at times when demand might exceed capacity. Build on elderly care service to ensure all patients eligible are reviewed in a timely fashion aiming to increase from current rate of 67% to >80%. *(local action)*
National Paediatric Diabetes Audit (NPDA)	**Key Successes** • Median HbA1c improved from 68 to 64 mmol/mol 100% compliance with HbA1c and BMI check in clinics Improvement in key care processes from previous year, particularly thyroid and albuminuria checks Improvement in additional health checks e.g. 4+ HbA1c, ketone testing, sick day rules, flu vaccine recommendation 100% compliance with care at diagnosis Significant reduction in emergency hospital admissions from 12.1% to 5.2% (national average 6.2%) **Key concerns** • Worsening deprivation profile

	• Still on 'Alert' for adjusted mean HbA1c • Scope for improvement in key care processes especially blood pressure (BP), urine, foot check - likely to be affected by Covid-19 pandemic • Higher rates of overweight and high BP need closer monitoring **Key Actions** *(local actions)* • Improved staffing • PDSN • Admin • Psychology • Ward staff training • Pump starts • Monitoring HbA1c trends • QI planning for Covid-19: • Virtual Libre/pump/CGM starts • DigiBete. Structured education • Annual reviews • Clinic Review Action Plan • Weekly patient huddles • DeApp for new patient education • Dedicated QI time
• Society for Acute Medicine Benchmarking Audit (SAMBA)	**Key Successes** • The consultant review within national standard was better compared to 2019 at 60% with ED patient review improved from 33% to 57% **Key Concerns** • NEWS done within 30 minutes dropped to 71% (2019 88%). This has been discussed within the unit and is now done timely **Key Actions** • Due to COVID-19 situation we have not changed a lot from this audit, but once COVID settles we will be able to do SAMBA 2021 and review with the results regarding further changes to functionality of the unit
The Trauma Audit & Research Network (TARN)	**Key Concerns** • Sickness in department meant TARN co-ordinator spent less time on TARN as working on shop floor covering shifts. TARN clerk left department in Jan leaving trauma nurse to submit data • The lifting of lockdown will increase numbers New TARN clerk to start April 2021. **Key Actions** • New clinical lead & Major Trauma nurse co-ordinator to have more meetings. *(local action)* • Clinical lead discussed with IT to see if a Cerner prompt to assist with identification of patients can be implemented. *(local action)*
UK Cystic Fibrosis (CF) Registry	**Key Successes** • New treatments now available including Trikafta which is hoped will further improve life expectancy **Key Actions** • CF specialist nurses to enter annual review plus 3 other clinical encounters per year for every patient *(local action)*
UK Renal Registry National Acute Kidney Injury Programme	Continuous data collection. The aim is to establish data flows to allow successful audit and quality improvement within three years. *(local action)*

The reports of 5 local clinical audits were reviewed by the provider in 2020/2021; there has been a very limited local audit schedule due to the pandemic. Wirral University Teaching Hospitals intends to take the following actions to improve the quality of healthcare provided	
Audit	**Action**
Urinary Tract Infections (UTI) in Children aged 6	1. Educate colleagues on difference between upper and lower UTI and how to correctly code the diagnosis. 2. Ensure accurate documentation around urine dip result - either under interactive view or on documentation.

months to 3 years	3. Show colleagues how to access the UTI guideline and antibiotic formulary on the intranet. 4. Educate the difference between atypical and typical UTI's. 5. Remind everyone about the reasons for follow up. 6. Implement in a teaching session and poster on ward/mess.
Management of Massive Obstetric Haemorrhage	Implementation of ROTEM (Rotational Thromboelastometry) use to optimise use of blood products through near patient testing. Will need new protocols to be approved, training of key personnel and embedding of a new point of care testing process
Audit of post Loop Management of Women over 50 years of age	Spreadsheet has been designed to monitor patients weekly ensuring robust failsafe arrangements. Cytology results are inputted onto Colposcopy ad hoc database and spreadsheet. Continue to ensure letter for post loop over 50's women with involved margins stresses the importance of attendance and follow up smears
Audit of GP referrals and triage decisions in Ophthalmology clinics	It was identified that the Optometrists are effectively triaging patients with a rate of almost 99%. Work is now ongoing with some GPs/GP practices to provide support booking patients into the Ophthalmology clinic that is the most suitable to the patient.
Biometry Review	The service continues to meet the Royal College of Ophthalmology benchmark standard of 85% within +/- 1D of PPOR Within 1% of average deviations over 1D from the previous 6 months and now also meeting target of 65% within 0.50D of PPOR. Only cases where a subjective refraction had been recorded have been analysed which is a significantly lower number than the actual total number of eyes operated on. Plans are in place to ensure that subjective responses are collected/recorded as much as possible, with further investigation required to find out why some subjective refraction data isn't being received.

2.4 Participation in Clinical Research

During 2020/2021 2,510 participants, receiving NHS services provided by the Trust, were recruited to participate in research approved by a Research Ethics Committee. In line with the National Institute for Health Research (NIHR) and Department of Health request, most standard research was stopped in order to focus resources on urgent public health research about COVID-19. Of the 2,510 participants recruited, 2,376 participated in COVID-19 research and 134 in non-COVID-19 research. During 2020/2021 the Trust approved nine new COVID-19 research projects.

Research within The Trust is supported by a small administrative team (3 WTE), 9 Research Nurses (7 WTE) and a Research Midwife (0.7 WTE). Much of the research involves collaboration with the North West Coast Clinical Research Network and academic and industry institutions. The Research Department works closely with pharmacy, pathology and radiology to ensure that The Trust has the capacity and capability to set up and effectively run its studies.

In 2020/2021, 79 new articles written by WUTH staff, published in professional journals were identified (as listed on PubMed, Medline and EMBASE). New publications are recorded and disseminated across the organisation in order to share new knowledge. This shows the Trust's commitment to improving patient outcomes, staff professional development and also to making a wider contribution to healthcare on a national level.

2.5 Commissioning for Quality and Innovation (CQUIN)

Updated guidance to the NHS was published during the third phase of the NHS response to COVID-19 which confirmed that the operation of CQUIN (both CCG and specialised) remained suspended for all providers until 31 March 2021. Providers did not need to implement CQUIN requirements, carry out CQUIN audits nor submit CQUIN performance data.

2.6 Care Quality Commission (CQC)

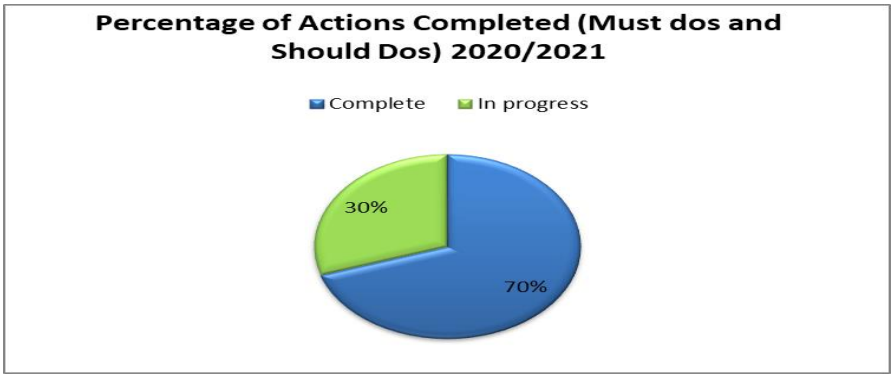
Wirral University Teaching Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered. Wirral University Teaching Hospital NHS Foundation Trust has the following conditions on registration:-

- The need for the Trust to secure delivery of services on a financially sustainable basis; and
- The need for the Trust to ensure compliance with the A&E four hour targets on a sustainable basis.

The Care Quality Commission has not taken enforcement action against Wirral University Teaching Hospital NHS Foundation Trust during 2020/21.

Following the publication of the CQC inspection report on 31 March 2020, the Trust has continued to make significant progress in both the response to the requirements and recommendations made within the report. Divisions; Corporate and Executive teams have reviewed the CQC findings and developed action plans to address the 31 must do's and 76 should do's with 351 actions, in total, identified to support achievement of full compliance and continued improvement.

Of the 107 overall requirements, 74 have all actions completed so therefore 70% of the overall action plan has been achieved with all remaining actions in progress.



The Trust underwent an unannounced, CQC focused inspection of infection prevention and control procedures at Arrowe Park Hospital from 15th to 23rd Feb 2021; with the full report being published in April 2021. Whilst the CQC did not rate the service at this inspection and confirmed that all previous ratings remain, the inspections finding were positive and demonstrated a significant improvement.

The inspection found:

- Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The trust had a clear vision and plan for continuously improving practices related to infection prevention and control and an action plan to meet identified goals. The action plan was aligned to local plans within the wider health economy.
- Staff felt respected, supported, and valued. The Trust had an open culture where staff could raise concerns without fear. They were focused on the needs of patients receiving care.
- Leaders operated effective governance processes. Staff at all levels was clear about their roles and accountabilities. Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.
- Leaders and staff collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services

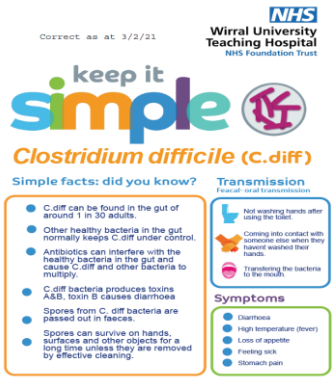
The inspection did not identify any areas of significant concern for Must Do action. There were three Should Do areas for improvement identified:-

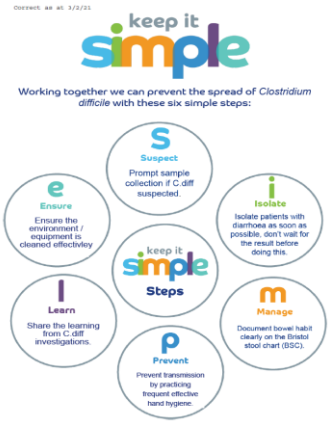
- The trust should ensure it develops an IPC strategy and monitors identified actions to improve practices related to infection prevention and control in line with local and national priorities at the relevant forums.

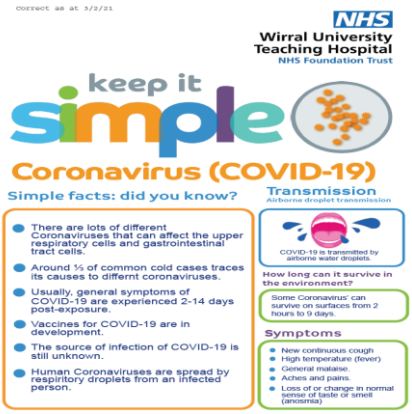
- The trust should ensure staff assesses the risk of, and takes action to prevent, the spread of infections through compliance with standard operating procedures and dynamic risk assessment with regards to the use of single rooms for patients with identified infections.

- The trust should ensure staff are aware of the personal protective equipment requirements, and adhere to appropriate national guidance, in relation to the wearing of eye protection when caring for COVID-19 positive patients.

Outstanding Practice: The inspection identify the Trust's 'Keep it Simple' campaign as an area of outstanding practice. This campaign communicates key messages about infection prevention and control to staff, patients and visitors. Brightly coloured posters and information leaflets were available throughout the hospital and staff could clearly articulate the key priorities outlined in the campaign:







2.7 Freedom to Speak Up

WUTH developed the role of Freedom to Speak up (FTSU) Guardians in 2015, prior to National guidance being issued by Sir Robert Francis. Since then, the Trust has been significantly involved in shaping National policy and guidance around this agenda and has been working hard to improve the speaking up culture within WUTH.

Three FTSU Guardians are currently in place, with a network of 18 FTSU Champions, whose role is to work within their service areas, supporting the FTSU Guardians and promoting and encouraging staff to speak up.

Where a member of staff does not feel able to speak up through the normal management channels, they are encouraged to contact an FTSU Guardian and will also be signposted to relevant support services as necessary.

The profile of the FTSU Guardian in the Trust remains prominent and a variety of Trust wide communication mechanisms are utilised to promote the importance of speaking up and the support available, including leaflets, pull up banners and articles within the Trust's in-touch magazine. Guardians form part of the staff induction process (including junior doctors) and FTSU training is now required for all staff at a level appropriate for their role, with compliance continuing to increase and subject to standard Trust monitoring processes. Guardians conduct walkabouts within areas to heighten visibility and are linked to departmental cultural reviews as additional support.

Staff can speak up to FTSU Guardians in confidence and make plans together about how best to move forward. Staff can access FTSU Guardians anonymously; although this can prevent effective management of the circumstances (due to insufficient information), and does prevent feedback and support to the individuals concerned. The Trust has seen a reduction in the number of anonymous

concerns raised as staff members are feeling more confident in approaching FTSU Guardians or local management teams.

FTSU Guardians maintain confidential records relating to information spoken up about and refer concerns to the most appropriate person e.g. Human Resources, management teams or staff side colleagues. Where further investigation is required, this is conducted independently by a senior and suitably trained person from elsewhere in the organisation if required. Progress is fed back to the reporter along with any outcomes or actions taken. FTSU Guardians monitor actions and outcomes, and will escalate circumstances if concerns still remain.

The service continues to see a positive increase in the number of staff speaking up, with 157 people speaking up this year as opposed to 106 people speaking up in 2019/2020. We continue to see a range of Occupational Groups speaking up, with staff speaking up across all Divisions

Attitudes and behaviours continue to be the most reported theme with 25 concerns linked with patient safety, compared to 12 last year.

There are also other sources of advice and support for staff with concerns. These include: tutors (for students and trainees); Practice Education Facilitators; the Human Resources department; Trade Unions and professional bodies and also the Guardian of Safer Working for our Junior Doctors. Whilst these services might not necessarily be able to investigate the concerns themselves, they can, for example, advise the employee about their rights, or support them if they are suffering stress because of the issue, so employees may wish to involve them in addition to contacting the Guardians.

The Trust has also developed a joint working protocol between the FTSU Guardians and the Counter Fraud Specialists.
The Trust also promotes a variety of wellbeing support options including; Occupational Health, Employee Assistance Programme, Psychological Wellbeing Practitioner and wellbeing hubs, along with a range of national and local community organisations depending on the individuals' circumstances.

The Trust's Diversity and Inclusion Lead has been identified as the Lead FTSU Guardian and as such, greater links have been made this year in supporting and encouraging those who may be less likely to speak up, with positive feedback received to date. Three Black, Asian and Ethnic Minority (BAME) FTSU champions were identified and promoted along with our new FTSU Guardian, with results highlighting a positive increase in the number of BAME staff now speaking up. The Trust has recently identified further FTSU Champions from its disability and LGBT+ (lesbian, gay, bisexual, transgender +) staff networks, with further Trust wide promotions to follow.

Regular reports are produced and submitted to a variety of Trust management Committees to ensure appropriate monitoring takes place of speaking up data, potential trends and themes and that the Trust is capturing and sharing any lessons learned. Data is also submitted quarterly to the National Guardians Office to ensure wider monitoring of speak up process and now also includes where staff feel they have suffered detriment as a result of speaking up and data is submitted to the National Guardians Office as required for further monitoring.

The Trust continues to link with regional and national FTSU Guardians and NGO representatives, so as to ensure consistency, best practice and support for FTSU Guardians is in place.

Staff members also have the right to raise issues with external regulatory bodies if they still do not feel comfortable with going through internal channels. These include: the National Speak Up Helpline, Care Quality Commission (for issues about patient safety and the quality of clinical services); NHS Improvement (for issues about finance and corporate governance); Health Education England (for education and training issues) and NHS Protect (where there are suspicions of fraud and corruption).

2.8 Hospital Episode Statistics

WUTH submitted records during 2020-21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

	% of records that include the patient NHS Number	% of records that include the patient's valid GP Practice Code
Admitted Patient Care	99.9%	99.9%
Outpatient Care	99.9%	99.9%
Accident and Emergency Care	99.4%	99.9%

2.9 Information Governance

Information Governance (IG) ensures processes and safeguards are in place to support the appropriate use of personal data. Any risks relating to IG are contained within the Trust monitoring and reporting mechanisms. They are reviewed by the Information Assurance Group (IAG). The IAG oversees that the Trust maintains compliance with relevant legislation and good practice and escalates anything of note to the Risk Management Committee.

The Trust is currently undergoing phase 1 of the required annual audit of the Data Security and Protection Toolkit (DSPT) which was undertaken by Mersey Internal Audit Agency but have not yet received the report.

As was the case last year, the submission date for the 2020/21 DSPT been extended owing to the current COVID-19 situation. Therefore the DSPT will not be submitted until June 2021. We did however achieve 'Standards Met' in the 2019/2020 submission in September 2020.

The main focus for the year has been supporting the pandemic efforts by enabling the personal data of patients and staff to be shared, where it is legal to do so, in an efficient and secure way. IG has also provided advice and written guidance to support staff when working remotely to ensure confidentiality continues to be maintained to the same standards as onsite.

We have also continued to embed the legal requirement for data protection impact assessments into the Trust's information sharing and information risk processes and encouraging a more data security conscious culture through continued education and awareness.

Data Breaches reported to the Information Commissioner's Office:

ICO Incident Number	Date	Incident Details
IC-90801-J4T0	26/02/2021	Incorrect disclosure to a patient's next of kin regarding their mental health which caused distress to the patient. Status: Under review.
IC-54034-W6J1	01/09/2020	A patient was discharged with another patient's Do No Resuscitate (DNR) form in error. The form contained the patient's demographics and the reason for the DNR decision. Status: No further action
IC-62125-S3F2	17/08/2020	Emails captured as part of a Subject Access Request were released to the requestor without some third party data being redacted. Status: No further action.

2.10 Clinical Coding

Accurate clinical coding is essential to the provision of effective healthcare at local and national level. It drives financial flows, informs payments and is critical to intelligent commissioning through the provision of epidemiological data that truly reflects the health and care needs of the nation.

In 2020/21 the Trust continued to commission an external audit programme from the Clinical Coding Academy at Merseyside Internal Audit Agency (MIAA). Two audits have been conducted by MIAA across the year. This provided substantial assurance.

The first of these was an audit of General Medicine coding performed in September 2020 with overall accuracy of our coded data reported as:

- 89.33% for primary diagnosis
- 90.83% for secondary diagnosis
- 95.42% for primary procedure
- 89.34% for secondary procedures

A second audit was performed on Obstetrics in January of 2021. The overall accuracy of our coded data is reported as:

- 83.00% for primary diagnosis
- 87.50% for secondary diagnosis
- 95.00% for primary procedure
- 89.34% for secondary procedures

These external audits were supplemented with additional internal audits throughout the year. The focus of the internal audits this year has been coding of COVID. We have two Approved Clinical Coding Auditors in post. The Trust was not subject to the Payment by Results clinical coding audit during 2020/2021.

The Trust will be taking the following actions in 2021/2022 to continue to improve data quality:

- Work with colleagues throughout the trust to improve the quality of our coded data with particular emphasis on clinician engagement and the improvement of documentation around coding for deceased patients.
- Continue to commission external clinical coding audits with expansion of our internal audit programme.
- Ensure the continual development of clinical coding staff, as well as ensuring all staff receives relevant feedback at individual and team level as appropriate.

Two staff members completed their initial coding training in November this year; this training had initially been scheduled for April. Training for two staff members, who completed their Standards course in March 2020 was delayed due to COVID pandemic. Examinations for the National Clinical Coding Qualification (UK) were suspended in 2020. This year one senior clinical coder moved to a Team leader role at a neighbouring Trust, one senior and one accredited coder moved to a neighbouring Trust as senior coders and one Team Leader moved to an Assistant Coding Manager role. We appointed internally into the Team Leader role and appointed an external candidate into the Trainee Trainer post. Trained clinical coders are a scarce resource and their recruitment continues to be challenging for the service as a whole.

2.11 Learning from deaths

The national program for reviewing in hospital deaths was suspended nationally in March 2020, due to the COVID-19 pandemic and recommenced on 23rd June 2020. However the Trust continued with a targeted review process to identify learning from patients who had died from COVID-19 and to also provide assurance that patients were receiving escalation to level 2 and 3 critical care

support. The Trust reviews established that patients who died from COVID were similar to those reflected in the national picture but the ratio between male and female was more balanced compared to the national reports of the male population being more at risk. There were no cases identified of patients being denied level 2 / 3 care.

Upon recommencement of the national Learning from Deaths program, all in hospital deaths were reviewed.

2.12 Seven day service

The Seven Day Hospital services programme aims to ensure that patients requiring emergency treatment receive high quality, consistent care every day of the week. The standards are intended to improve the care given to patients by enabling early and consistent senior decision making along with other urgent services. Ten clinical standards for seven day services were developed in 2013 through the seven day Forum, of which four were identified as national priorities for implementation by 2020 on the basis of their potential to positively affect patient outcomes.

As national benchmarking is no longer available and Trusts are encouraged to self-assess utilising an assurance framework, WUTH continues to monitor performance against the Seven Day Services Clinical Standards.

Although we are not reaching the 90% compliance for consultant review, there is evidence from clinical colleagues that documentation both of a consultant review or documentation of an agreed clinical pathway is a factor in non-compliance. Actions are in development to increase awareness to improve compliance.

The table below demonstrates the improvements throughout 2020/2021

Standard 2	Q1	Q2	Q3	Q4
Weekday	69%	64%	62%	72%
Weekend	66%	61%	55%	63%

2.13 Core Indicators

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

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
1 - Preventing People from dying prematurely							
	Summary Hospital-Level Mortality Indicator (SHMI) value and banding (most recent data available to December 2020)	01/01/2020 - 31/12/2020	1.06 Banding 2 'As Expected'	1.00	0.70	1.18	1.11 Banding 2 'As Expected'
	Percentage of deaths coded for palliative care	01/01/2020 - 31/12/2020	50	37	7	61	49
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: Information relating to mortality is monitored monthly and used to drive improvements. The mortality data is provided by an external source (Dr Foster). Wirral University Teaching Hospital has taken the following actions to improve this indicator, and so the quality of it services: Strengthening the Trusts mortality review process Appointment of Trust Medical Examiner Regular mortality team meetings						

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
3 - Helping people to recover from episodes of ill health or recover from injury							
	Patient Reported Outcome Measures (PROMS) - Primary Hip Replacement Surgery	April 2019 – March 2020	0.427	0.455	0.352	0.538	0.423
	Patient Reported Outcome Measures - Primary Knee Replacement Surgery	April 2019 – March 2020	0.286	0.333	0.215	0.419	0.214
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: The questionnaire used for Patient Reported Outcome Measures is a validated tool and administered for the Trust by an independent organisation, Quality Health. Wirral University Teaching Hospital continually takes the following actions to improve this indicator and so the quality of it services by Delivering a number of actions to improve patient experiences following surgery. Data for 2020-2021 has not been published						
	Percentage of emergency admissions to any hospital in England occurring within 30 days of the most recent discharge from hospital after admission	2019- 2020 <16 years	18.5	11.8	2.2	56.7	19.3
		2019- 2020 >16 years	13.3	11.9	1.9	37.7	13.1
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: The data is consistent with Dr Foster's standardised ratios for re-admissions. The data is monitored monthly by the Trust Board. Wirral University Teaching Hospital continually takes the following actions to improve this indicator and so the quality of it services by Working to improve discharge information as a patient experience priority. Reviewing and improving the effectiveness of discharge planning.						

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
4 - Ensuring people have a positive experience of care.							
	The Trusts Responsiveness to personal needs of its patients	2019-20	68.4	67.1	59.5	84.2	66.8
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: The data is submitted monthly to NHS England and the Trust actively encourages completion Wirral University Teaching Hospital intends to taken, and has taken the following actions to improve this indicator and so the quality of it services by: Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and innovative technology						
	Staff recommend the Trust as a provider of care to their family and Friends	2020	67.9%	74.3%	49.7%	91.7%	67.9%
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: An independent provider, Quality Health, provides the data. Wirral University Teaching Hospital has taken the following actions to improve this percentage score and so the quality of it services by: Engaging with all our staff to develop our Vison and values set. Creating and Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff. Freedom to Speak Up champions available for staff to access						

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
5 - Treating and caring for people in a safe environment and protecting them from avoidable harm							
	Patients admitted to hospital who were risk assessed for venous thromboembolism	Data collection for this indicator was paused in March 2020, by NHS England					
	Rate of C.difficile infection (hospital onset)	2019/20	20.1	13	0	51	30.3
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: • Review of the data collection process and the introduction of a sign off process to validate the data						
	Patient safety incidents	Oct 2019 -Mar 2020	No: 6096 Rate: 47.5	6502	1271	22340	No: 6442 Rate: 49.9
	Percentage of patient safety incidents that resulted in severe harm or death.		9	20	0	93	8

	Wirral University Teaching Hospital considers that this data is correct for the following reasons:
	• Wirral University Teaching Hospital considers that this data is correct for the following reasons
	  • The Trust actively promotes a culture of open and honest reporting within a culture of fair blame.
	  • The data has been validated against National Reporting and Learning System (NRLS)
	  • Each patient safety incident is reviewed for accuracy prior to upload to NRLS
	  • Wirral University Teaching Hospital has taken the following actions to improve this number and rate and so the quality of it services by
	  o Undertaking comprehensive investigations of incidents resulting in moderate or severe harm and utilising varying forums for learning such as huddles and Trust Communications including a Safety Bulletin.
	  o Providing staff training in incident reporting and risk management.
	  o Monitoring through the serious incident review group and patient safety board						

Part 3

3.1 Overview of the Quality of Care and Performance

The WUTH Quality Strategy 2019-22 was approved by Board on 1st May 2019 and described the road map to enable WUTH to provide not just great care, but the best care that can be provided for the people of Cheshire & Merseyside. The strategy is spilt into four quality campaigns and underpinning each campaign is a range of metrics designed to monitor the implementation of the strategy over the three year period. Year 1 of the Quality Strategy was predominantly around establishing the framework for implementation, establishing baselines and training for Quality Improvement Pioneers to ensure a firm foundation for driving improvement through year 2

In September 2020, the decision was made to suspend requirements of the Quality Strategy whilst the Trust focused its resources on maintaining patient, staff and public safety and quality during the COVID-19 pandemic. During the past twelve months the focus for the Trust has been on managing the activity resulting from the pandemic whilst maintaining patient, staff and public safety.

Campaign 1 – A Positive Patient Experience

Key Outcome	Year 2 Threshold/ measure	Year 2 Position Status	Progress Update
Focus on explaining care in an understandable way	≥95% or more patients satisfied their care was explained in an understandable way	Data suspended during COVID	Patient experience formal collection methods were suspended during the past 12 months due to covid - 19. Methods are in place to support reinstatement. Small sample Friends & Family Test data has been sampled via text messaging service since December 2020. During COVID the Trust has introduced a Family Support Team to support families and patients to ensure information is provided in an understandable way. Some wards introduced medical telephone rounds also to support this during the pandemic.
Engage and involve people in planning and delivering their care	≥90% or more patients reporting they were involved in planning their care	Data suspended during COVID	As above
Service users will be active participants of Patient Safety Quality Board (PSQB), Quality Committee and Divisional Governance Groups	Patients/service users will attend and participate in proceedings of divisional governance meetings	Suspended during COVID	Pre covid service user including health watch, age concern, mencap etc were invited to Patient Family and Experience Trust meetings.
Patient stories and pathway diaries used to better understand patient experience and identify touch points and Always Events	At least 1 Always Event a quality priority in each Division and providing a positive impact on patient experience	Suspended during COVID	Suspended during Covid-19. 1 Always event completed in surgery pre covid relating to mealtime experience.
	Patient stories are integral to the process of sign off and learning from serious incidents		Patient stories are used at each Trust Board meetings.

Campaign 2 – Care is Progressively Safer

Key Outcome	Year 2 Threshold/ measure	Year 2 Position Status	Progress Update
Reducing Hospital Acquired Infections	5% below trajectory for hospital acquired Clostridium difficile	Qtr. 1 = 16 Qtr. 2 = 6 Qtr. 3 = 23 Qtr. 4 = 17 **2020/21 = 62**	Baseline 2019/20 >88 cases 5% reduction = >83.6 .

	≥700 consecutive days without Methicillin Resistant Staphylococcus Aureus (MRSA) bacteremia	Qtr. 1 = 1 Qtr. 2 = 1 Qtr. 3 = 0 Qtr. 4 = 0 **2020/21 = 2**	2 x cases in 2020/21
Achieve high reliability of risk assessment and effective care bundle for patients at risk of falls	≥95% or more compliance with implementation of falls care bundle for at risk patients	Perfect Ward Falls Bundle over 65 Qtr. 1 = 81.1% Qtr. 2 = 82.1% Qtr. 3 = 87.2% Qtr. 4 = 90.5% **2020/21 = 85.2%** Perfect Ward Falls Bundle under 65 Qtr. 1 = 98% Qtr. 2 = 98.6% Qtr. 3 = 98.3% Qtr. 4 = 98.5% **2020/21 = 98.3%**	Completion of risk assessments and care planning is monitored via the harms audit / falls section within the perfect ward. Falls risk assessment compliance has also been reviewed as part of the harms panel .
Achieve an effective pressure ulcer prevention plan for those patients at risk of hospital acquired pressure ulcers	≥95% or more compliance with implementation of pressure sore prevention plans for at risk patients	Qtr. 1 = 98% Qtr. 2 = 98.9% Qtr. 3 = 99% Qtr. 4 = 98.2% **2020/21 = 98.5%**	WUTH uses Braden as its risk assessment tool - average for the year 96.75% Risk assessment and care planning is monitored via the Harms audit within the pressure ulcer section within perfect ward. Compliance is also monitored for specific cases via the combined harms panel. The Trust has appointed a Tissue Viability lead Nurse who has revised work plan of focused improvements for 20211/22.
Achieve high reliability of end-to-end care for patients at risk of venous thromboembolism (VTE)	90%	Data suspended during COVID	Due to the suspension of the Quality Strategy in 2020 the administration of venous thromboembolism prophylaxis data hasn't been routinely reported as the VTE Steering Group was suspended due to COVID-19. .
Focus on safety culture in operating theatres and other areas where interventional procedures are undertaken	100% compliance with World Health Organisation (WHO) Checks	**2020/21 = 99.1%**	Work has been ongoing to further strengthen the implementation of WHO 5 steps the safer surgery. An audit process is established with monthly reporting to division of surgery Safety and Quality Board. Audits reflect 99.1% compliance; areas for improvement include engagement with the tool and to reduce noise/distraction. A WHO safer surgery action team has been established to drive improvements as a result of learning from ongoing audits. The group aim to improve engagement and compliance with the checklist and, as such, have revised the checklists, based on learning and feedback on engagement and reviewed the policy. The group are looking to understand the safety culture factors that influence active engagement with the tool and aim to complete this work in May 2021 Plans are in place to develop a Safety Board and to move from paper operating lists to a digital operating list for theatre teams and clinicians. This improvement will provide accurate patient level information to the safety brief; provide a safe environment for staff attending theatre to be briefed on the patient list and also the patient being operated on. The team has embedded WHO questions within the Theatre Accreditation Process that is in development; next steps are to move to testing stage.
	At least 6 consecutive months without surgical Never Event	**2020/21 = 1 surgical never events**	A Never Event relating to wrong site biopsy was declared on 1st Feb 2021; the previous Never Event to this was declared almost twelve months earlier on the 20th Feb 2020. The Never Event in Feb 2021 related to a 73 year

			old patient with lung cancer and widespread metastatic progression under the care of Clatterbridge Cancer Centre (CCC) attended the CT department for a Para spinal biopsy for molecular markers. On the day of procedure, patient instead consented for, and underwent, lung biopsy in error. Recommendations from this Never Event included: - The CT checklist should be updated to include a requirement for the requested biopsy site to be included. Education and learning must be provided for relevant radiologists and radiographers on the importance of LocSIPPS and the importance of a team approach. CT protocol for biopsy requests should include review and clarification of the biopsy site. Where possible, operators should not have CT biopsy and IR lists scheduled on the same day as to avoid delays or cancellations for patients, and reduce unnecessary pressure on operators and the wider team. Appointment slots for CT biopsy should be increased to at least 1 hour to ensure sufficient time to safely perform biopsy procedures, including allowing for additional time to complete appropriate IPC actions
Reliable daily completion of charts and calculation of +/- fluid balance	95% Fluid balance is monitored for group specific patients i.e. sc fluids / catheter / clinical indication	Qtr. 1 = 89.3% Qtr. 2 = 88.7% Qtr. 3 = 89% Qtr. 4 = 88.5% **2020/21 = 88.9%**	Several work streams have been identified to support improvements in this area. The Nutrition and Hydration group oversees the workplan and ensures progress against the key priorities. Developments are underway to enable effective compliance reporting utilising automated reports from Cerner , perfect ward and the BI portal
	Deteriorating patients(mews >5) 95%	Qtr. 1 = 78.7% Qtr. 2 = 85.6% Qtr. 3 = 72.5% Qtr. 4 = 64.6% **2020/21 = 75.4%**	There are a number of work streams being developed to support a reduction in Medical Emergency Team (MET) calls and changes that have already been introduced; although the pandemic has impacted on progress this year. These include National Early Warning Score2 (NEWS2) score trending; this means if a patient has a NEWS2 score that would trigger a MET Call and is subsequently reviewed by a senior medic with a management plan in place, they do not require a repeat call if they remain above the trigger threshold, but their score is improving (i.e. they are responding). Medical follow up/oversight would still occur. However, should the score deteriorate; this would trigger a repeat MET call; this is reflected in the NEWS2 policy. Ways are being explored of adjusting the trigger scores appropriately and safely for patients who are known to have elevated baseline NEWS2 (as their norm, where this is known). Temperature checks of the understanding with ongoing education around staff knowledge and application of the NEWS2 policy are also in place. A Quality Improvement Programme is planned around NEWS2 (related to recognition of deterioration and appropriate escalation), some of which will touch on MET calls. There needs to be improved quality data to fully understand the issues around MET calls; discussions are ongoing with IT to improve data relating to MET calls. As part of mandatory training staff are required to complete two E Learning modules relating to the deteriorating patient; NEWS2 / Deteriorating patient.

			Deteriorating patient and Sepsis
Delivering harm-free care	97%	National reporting ceased	National reporting on this indicator has ceased.
Safe staffing: Reduce the incidence of staffing levels as direct causal factor in harmful incident reports	Reduce the incidence of staffing levels as direct casual factor in harmful incident reports. Reduce by 3% (based on 2019/20)	Metric needs review	The Trust has developed enhanced monitoring systems for staff to ensure staff are appropriately deployed in line with patient acuity, skill mix and professional judgement. The Trust has developed a Safe Staffing Oversight Tool which displays staffing levels in each area across the organisation that is visible at all levels of the organisation. This tool also captures reflection based on any staffing level which is below the planned to capture any red flags or harms that have occurred as a result of reduced staffing. The impact that staffing has on harms is also reviewed and captured as part of the combined harms panel and the serious incident process. The Trust also utilised the winter safe staffing escalation plan during COVID to reduce the risk of lapses in care occurring due to inadequate staff levels.
Safe staffing: Focus on maximising staffing rates in rotas	Care Hours Per Patient Day (CHPPD) 6-10	Qtr. 1 = National reporting suspended Qtr. 2 = 9 Qtr. 3 = 9.4 Qtr. 4 = 8.7 **2020/21 = 9**	Reporting was suspended due to COVID this has been reintroduced Dec 2020. National measure is CHPPD rather than fill rates. The Trust has introduced a monthly safe staffing paper and dashboard that is presented to the Board of Directors Trust board. CHPPD 8.9 Feb Data: RN Day - 81%, CSW Day - 91% Registered Nurse Night - 84% Care Support Worker Night - 71% The Trust utilised the winter safe staffing escalation plan during COVID to reduce the risk of low staffing numbers. The Trust also utilised the Aspirant Nurse programme to support experienced student nurses to work as part of the workforce. In addition the use of the nurse incentive scheme from October 2020-June 2021 and Agency Nurses from Jan – March 2021 has relieved the pressure on vacancies. The International recruitment plan remains on track to deliver 107 overseas nurses to the Trust before June 2021 and CSW offers of employment are expected to reduce CSW vacancies to 0 by the end of Q1 2021/22.
Safe staffing: Sequentially reduce Band 5 vacancies	Sequentially reduce Band 5 vacancies	Metric requires review.	WUTH has implemented an international recruitment programme in which it aims to recruit 107 qualified nurses. It is anticipated RN vacancies will reduce to 4% by the end of June 2021. The Trust also maintains an open advert for band five registered nurse vacancies shortlisting and interviewing weekly as applicants apply.
Apply for Royal Society for the Prevention of Accidents (RoSPA) accreditation of safety management system	Awarded SILVER	Awarded GOLD year one	The Quality Strategy set a key objective to achieve a Bronze Award in 2019/20 moving through to Gold Award by 21/22 (Achievement Award). There were 19 standards for this application and examples of judgement criteria and performance criteria to be met for the each of the standards. The Trust was awarded Gold for 2019/20. The Trust has submitted its RoSPA application for 2020/21and whilst the judgement criteria remained unchanged the focus of this application included work undertaken to address and manage the risks associated with COVID-19 within our Trust. The evidence submitted included a range of risk assessments, standards operating procedures and

			reference to the establishment of forums including the Personal Protective Equipment Group and Environmental Group to manage COVID19 risks. The application also included reference to the work undertaken following the repatriation of British Nationals from WUHAN and the positive national and international recognition this work received. As a result of COVID19 the results of this application have been delayed and will be released by RoSPA in June 2021.
Minimise and/or respond early and effectively to the signs of clinical deterioration	Reduce by ≥25% Medical Emergency Team (MET) Calls	2020/21 = 3126 Target to achieve based on a reduction of 25% for 2019/20 = 2272	See comments re Modified Early Warning Score (MEWS).
Ensure every patient (not medically optimised) is reviewed by a senior doctor (ST3 or above) at least once daily	90%	No data recorded	Achievement of this indicator remains a challenge; this is largely related to the need to improve documentation within patient notes. The Silver Command bed template has been amended as an interim solution for senior doctor review which now includes a spot check reminder.

Campaign 3 – Care is Clinically Effective and Highly Reliable

Key Outcome	Year 2 Threshold/ measure	Year 2 Position Status	Progress Update
Reducing harm for those using our services who have a learning disability	Reduce by 10% (based on 2019/20) number of harmful incidents involving learning disabled patients	Metric requires review	Baseline completed indicating there were 22 incidents in 2020-21. Reduction target is 1.1 incidents. Learning outcomes from the baseline identified incorrect classification of learning disability. This will be addressed through training and education. No trends currently from the data. Incidents will be categorised to support with the data cleansing. There were 5 reported incidents which have been downgraded as no harm after investigation. These were all around medication incidents. All Learning Disability patients have their DNACPR status reviewed by an LD nurse to ensure appropriate decisions are being made and documented in line with latest recommendations.
Reducing % of patients with ≥3 emergency admissions in the last 90 days of life	Metric under review	Metric requires review	Data collection for admissions for end of life patients was suspended.
Hospital Standardised Mortality Ratio (HSMR)	≤100 - below 5% of expected range	Dr Foster Feb 2020 - Jan 2021 = 100.9	The Trust currently has a HSMR of 100 and now within expected range for both Summary Hospital-Level Mortality Indicator (SHMI) and HSMR (latest SHMI is 108.8) Coding work commenced in November 2020 and the latest figures show the impact of the first month of that work. It is anticipated that the coding work will continue to positively impact on mortality data.
Mortality Reviews	Factors associated with mortality ≤2%	1.22%	Medical examiners currently escalate deaths to the mortality review group for further investigation. Cases are categorised into a number of groups, including family / carer concerns, death following elective admission, deaths in patients with learning difficulties, identified wider learning for system improvement and where there were significant concerns on the quality of care.
Improve effectiveness of discharge planning and resilience of discharge venue	Achieve at least 90% or more patients reporting they were involved in planning their discharge	Data suspended due to COVID	Patient experience formal methods were suspended during the past 12 months due to Covid - 19.

	Reduce by 5% (based on 2019/20) number of incidents concerning unsafe /unsatisfactory discharge	2%	Patient experience formal methods have been suspended during the past 12 months due to covid - 19. The Trust has an' Improving Patient Flow' programme in place which is overseen by Patient Flow Improvement Group and the Programme Board. Updates and assurances as to progress are regularly provided to Trust Board. Analysis of incidents shows there has been a 2% reduction in the number of recorded incidents concerning unsafe / unsatisfactory discharge (2019/20 = 230 / 2020/21 = 225). It is difficult to compare the two figures as bed capacity and the impact of COVID-19 discharge pressures, particularly in wave 1 will influence the data.
	Reduce by 5% (based on 2019/20) number of complaints concerning unsafe /unsatisfactory discharge	**2020/21** **Level 1 = 108** **Level 2-4 = 31** **2019/20** **Level 1 = 106** **Level2-4 = 11**	Complaints for year 2 regarding unsatisfactory discharge has increased since last year. There has been a small increase in level 1 complaints for quarter 4 2020 /21 regarding unsatisfactory discharge from the baseline from last year. (108 complaints compared to a baseline of 106) It is difficult to compare the two figures as bed capacity and the impact of COVID-19 discharge pressures, particularly in wave 1 will influence the data Discharge planning is also being addressed on the CQC Action Plan.
Improving the timeliness of the clinical response to abnormal or unexpected (and clinically significant) radiology or pathology results	10% fewer serious incidents (compared to 2019/20) involving failure to detect and act upon (clinically significant) abnormal pathology or radiology findings	Audit scheduled June 2021	Radiology developed and implemented a follow-up process for all diagnostics tests where a 'Serious Unexpected Findings' has been identified. The outcome was been achieved for year 1 and the process has remained in place. A compliance audit is scheduled for June 2021.
Compliance with National Institute for Health and Care Excellence (NICE)	≥90% of Clinical Specialties completed baseline assessment against all applicable NICE guidelines	Qtr. 1 = 99% Qtr. 2 = 99% Qtr. 3 = 100% Qtr. 4 = 100% **2020/21 = 100%**	100% compliance has been achieved for this target. The implementation of Clinical Effectiveness Committee in Q1 2021/22 will monitor outstanding actions by specialty to ensure NICE compliance.
Ensuring all patients have a review by a Consultant within 14 hours of hospital admission	≥98%	Qtr. 1 = 68% Qtr. 2 = 59% Qtr. 3 = 61% Qtr. 4 = 68% **2020/21 = 64%**	A point prevalence audit is undertaken quarterly. Target not achieved for senior review, compliance is considered to be attributed to poor documentation within patient notes.
Implementation of Central Alert System (CAS)	≥99% closure on or before deadline day	**2020/21 = 100%**	100% compliance has been achieved for the process of responding to and signing off CAS alerts in year 2. Year three will strengthen arrangements for the implementation and embedding of actions from alerts.
Culture of enquiry and continuous improvement	≥75% of staff report they are able to contribute to improvements at work (staff survey)	2020 = 69.3% 2019 = 71.6% 2018 = 68.2%	Work has been ongoing to support improvement in this area: New Management Development Framework to develop managers Focus Occupational Development on teamwork and developing teams Review the questions that have fallen over time or score low, and develop improvements around these areas Improve awareness of our Speaking Up policy and process so that staff feel safe to do so Divisional Triumvirates and Corporate Heads of Service will receive more detailed information relating to their areas in order for plans to be developed to address the issues identified within their areas. These will be discussed at the internal Workforce Steering Board and where appropriate, monitored via the Divisional Performance Reviews. The final results and action plans will be reported

			via workforce governance meetings, Divisions and to Trust Board.

Campaign 4 – We Stand Out

Key Outcome	Year 2 Threshold/ measure	Year 2 Position Status	Progress Update
Staff engagement/Satisfaction	KF1: Staff recommendation of the organisation as a place to work is ≥4.0	2020 = 62.1% 2019 = 60.5% 2018 = 55.2%	Work has continued to improve communication with staff via Leaders in Touch Forum briefings which are open to all staff and regular In Touch bulletins. There has been a change in measurement of staff engagement/ satisfaction nationally; this is now scored on scale of 0-10 and benchmarked against other similar Trusts nationally.
Getting to the learning faster: response to serious incidents	≥80% of incidents scoped within 72 hours of incident occurring or sooner		During the pandemic period the 60 day timeframe requirement for completion of Serious Incidents was suspended nationally. Throughout this period the Trust continued to strive to maintain this timescale. The timescales for the completion of a rapid review with 72 hours of a patient safety incident being identified was increased to 5 days during the pandemic, due to the pressures on clinical capacity. However this has now been resumed to 72 hours as business returns to usual. Compliance is monitored via the weekly Serious Incident Panel.
Learning from high risk events	Reduction in medication incidents reported causing harm	Harm rate 2017/18 - 7.9% 2018/19 – 6.0% 2019/20 – 4.6% 2020/21 – 5.1%	Considerable work has been undertaken to ensure that harm categorisation is correct as historically there was some 'over scoring'. Model hospital data for median harm rate nationally is 11%.
	Reduction in numbers of wrong patient medication errors reported	2017/18 – 37 2018/19 – 29 2019/20 – 32 2020/21 - 31	Progress monitored via Medicine Safety Optimisation Panel. Multiple actions completed to address including thematic analysis, screen savers, bulletins, druggles, #safemedsadmin film, and socialising of high risk situations. Trust Wide response to wrong patient incidents required as issue is not unique to medicines. Risk put on risk register June 2020.
	Reduction in numbers of incidents reported regarding incomplete or ambiguous discharge summaries or failed nursing medicines checks at discharge	2019/20 – 100 2020/21 - 136	There has been a recent focus on reporting these incidents by Primary care networks pharmacy staff to gain a better understand the extent of the issue. An initial improvement seen following targeted improvement work and the 'stop the line' project has not been maintained through the COVID pandemic and new cohorts of junior medical staff joining Trust.
	5% reduction (based on 2019/20) in number of reported instances of falls involving moderate/severe	2019/20 = 0.12 2020/21 = 0.16	Falls with moderate or above harm remains below the agreed target on the Quality Dashboard In November a revised Falls tracker was developed to incorporate additional review indicators from learning outcomes, in addition the preparation form was changed to streamline the review and make the process more efficient. Weekly themed review is undertaken of falls with targeted actions based on review.

	5% reduction (based on 2019/20) in number of reported instances of hospital acquired pressure ulcers	**Pressure Ulcers - Hospital Acquired Category 3 and above** **2019/20 = 3** **2020/21 = 10**	Increase in assessments carried out in the emergency department and increase in number of incident forms identifying pressure ulcer damage on admission to the Trust. Improved assurance process regarding pressure ulcers. Risk assessment and care planning is monitored via the Harms audit within the pressure ulcer section within perfect ward. Compliance is also monitored for specific cases via the combined harms panel. There is a designated tile within the Bi portal for tissue viability which includes a holistic dashboard incorporating elements of risk assessments and care planning. Tissue Viability has been agreed at Patient Safety Quality Board in April 2021 to be an area of Quality Improvement coaching focus. The Trust has appointed a Tissue Viability lead Nurse who has a revised work plan of focused improvements for 2021/22.

3.2 Serious Incidents

We are committed to identifying, reporting and investigating serious incidents and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence:

- A Weekly Serious Incident Panel is held within the Trust, this multidisciplinary group with senior clinical membership reviews all newly reported incidents reported as resulting in significant harm and reviews all investigations undertaken as a result of a serious incident.
- Patient Safety Quality Board (PSQB) and the Quality Assurance Committee provides assurance on the follow up of incidents and the implementation of learning, including undertaking more detailed reviews of any areas of concern identified.
- Patient Safety Bulletins are disseminated weekly to ensure all of our staff members are able to learn from our experience.

3.3 Never Events

The NHS Never Events list provides an opportunity for commissioners, working in conjunction with Trusts, to improve patient safety through greater focus, scrutiny, transparency and accountability when serious patient safety incidents occur. Nationally the most commonly reported Never Events relate to retained surgical items, wrong site surgery, and wrong implants.

We have reported one Never Events during 2020/21 under the following categories:

- Wrong site surgery

The Never Event underwent a full investigation by the Trust and learning has been disseminated and discussed through the appropriate routes with the CCG. Further detail about the learning from these Never Events and other Serious Incident investigations is discussed regularly to support a learning culture.

3.4 Pharmacy

During 2020-21 the non-essential audit programme within the Pharmacy department was significantly reduced due to the pandemic. Resources were diverted elsewhere to enable the launch

of the COVID-19 Vaccination Hub, providing vaccinations for the community of the Wirral, led by the Pharmacy department.
Some of the further essential work continued by the Pharmacy department, and the work done to mitigate the COVID-19 impact, is detailed below.

Compliance with discharge summary standards for medicines

The Mersey Internal Audit Agency (MIAA) audit found compliance with the required standard for notifying GPs of medication stops, starts and changes improved from 29% in April 2019 to 71% in January 2020. At the outset of the COVID-19 pandemic it was identified that accurate discharge information was critical to reducing the burden in primary care and preventing re-admissions. A quality assurance project via pharmacy shielding staff reviewed the discharge summary of every patient who had an inpatient stay of greater than 24 hours, to compare the information in the discharge summary to the medicines reconciliation to ensure that all changes to the patient's medicines were documented with the rationale. Any discrepancies were corrected and an updated copy of the discharge summary was sent to the patient's GP. This project found the proportion of discharge summaries requiring pharmacy intervention fell from 45% at the start of the project in April 2020 to a low of 7.7% in August 2020.

Whilst this project was successful and resulted in correct information being transferred to primary care for all patients during the COVID-19 pandemic, the pharmacy resource deployed to this programme returned to the work place after shielding. Therefore the capacity for monthly spot checks is under discussion within Pharmacy to provide assurance that the improvement is being maintained. If non-compliance with the policy is noted, it will need to be considered whether it is possible to reinstate aspects of the quality assurance programme as a short life project to drive improvement.

Controlled drugs audit

The number of areas 100% compliant with standards significantly improved in the pharmacy audit; 70% (56/80 areas) in Q4 and 60% in Q3 (49/82 areas), where this has previously not been higher than 45% in the 18 months previously. Auditors have noted improvement across the Trust and targeted improvement work was particularly successful in the Emergency Department, Theatres & Wards 25, 26 & 27, driven by Perfect Ward audit results, with real time feedback being given to staff by invested area leaders. Improvement work continues to be required to deliver full compliance with the CD regulations.

3.5 Trust Performance Indicators

The indicators in this section have been identified by the Trust Board in consultation with stakeholders or are a national requirement and are monitored throughout the year indicated in table below:

Quality Account 2020/21 – Performance Metrics		
Performance Indicators	**Target**	**Full year**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Minimum 80%	69.26%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge(Arrowe Park site)	Minimum 95%	79.95%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (WUTH ED only)	Minimum 95%	76.21%
All cancers: 62-day wait for first treatment from: Urgent GP referral for suspected cancer	Minimum 85%	83.28%
NHS Cancer Screening Service referral	Minimum 90%	86.50%
C. difficile: variance from plan	Maximum 72 cases	62 10 cases

	p.a.	below maximum
Maximum 6-week wait for diagnostic procedures	Minimum 99%	97.4%
Venous thromboembolism (VTE) risk assessment	Minimum 95%	94%

3.6 Staff Survey

The NHS Staff Survey results were released in Quarter 4, having taken place between September and November 2020. Surveys were issued to 6217 WUTH staff, of which 2,492 were completed and returned. The response rate was 40.9% (rounded to 41%) which is an improvement on the 2019 survey, which saw a response rate of 38% (2,265).

Key headlines for 2020 were:

- A stable set of results in a challenging year, with no theme areas declining significantly
- Really pleasing progress in staff experiences on theme of bullying and harassment
- Improvements in the Equality, Diversity and Inclusion theme, which are very encouraging
- Recognition of the Trust's zero tolerance approach to violence against staff
- Improvements in 'Safety Culture' theme
- Areas for improvement in teamwork and line management
- Support for continuing focus on staff health and wellbeing

The results from the Quality Health report are highlighted below based on comparisons to our benchmark group of 61 Acute or Acute & Community organisations in the NHS. Positive headlines include increases in areas where we have taken proactive steps to deliver meaningful actions and also to raise awareness amongst staff. These areas, shown in green highlight below, indicate positive changes to staff perceptions of our performance in Equality, Diversity and Inclusion (EDI) and Safe Environment, Bullying and Harassment, which is very encouraging to see and reflects the focus of Trust action in these very important areas of staff experience.

Theme	WUTH 2019 score	WUTH 2020 score	2020 Sector Average	Statistically Significant Change
Safe Environment - Violence	9.4	9.55	9.49	↑
Equality, Diversity & Inclusion	9.2	9.31	8.96	↑
Safe Environment Bullying & Harassment	7.8	8.15	8.0	↑
Quality of Care	7.4	7.5	7.5	↑
Staff Engagement	6.8	6.88	7.0	→ ←
Immediate Managers	6.7	6.66	6.8	→ ←
Safety Culture	6.5	6.61	6.76	→ ←

Team working	6.3	6.31	6.5	
Morale	6.1	6.16	6.23	
Health and Wellbeing	5.7	5.97	6.07	

Changes in the 10 themes since 2019 survey compared to the sector:

- 2 have scored significantly better than the sector - Equality, Diversity and Inclusion and Safe Environment (Bullying and Harassment))
- 7 show no significant difference to the sector average
- 1 scored significantly worse than the sector - Team working.

Changes in the 10 themes compared to the previous survey in 2019:

- 2 themes have scored significantly better in the 2020 survey (Safe Environment Bullying and Harassment and Safe Environment – Violence).
- There are no significantly worse themes

Areas of focus for the forthcoming year:

- Improving team working
- Training for immediate line managers
- Tackling residual bullying behaviour
- Continued focus on health and wellbeing to support staff further through what has been the most challenging time in the history of the NHS.

Appendix One

Appendix 1

List of relevant Health Services provided by the Trust

ACUTE AND MEDICAL SPECIALTIES DIVISION (19)

Emergency Department	Respiratory
Acute Medicine	Rheumatology
Critical Care	Haematology
Department of Medicine for the Elderly	Endoscopy
Cardiology	Dermatology
Gastroenterology	Stroke
Diabetes and endocrinology	Rehabilitation
Nephrology	Palliative Care
Cardio-respiratory investigations Lab	Integrated Discharge Team
Rehab	

DIAGNOSTICS AND CLINICAL SUPPORT DIVISION (11)

Pathology	Radiology
Bed Management	Therapies
Integrated Discharge Team	Sterile Services
Booking and Outpatients	Pain Management
Limb Centre	Pharmacy
Cancer Pathway Management	

SURGICAL DIVISION (17)

Surgical Elective Admissions Lounge	Oral and Maxillofacial
Pre-operative Assessment	Urology
Surgical Assessment	Trauma and Orthopaedics
Surgical Day Case	Ear, Nose and Throat
Colorectal	Upper Gastro-intestinal
General Surgery	Emergency General Surgery
Audiology	Chronic and Acute Pain
Ophthalmology	Theatres and Anaesthetics
Lymphoedema	

WOMEN'S AND CHILDREN'S DIVISION (10)

Paediatrics (Children's Ward / Paediatric Assessment Unit)	Community Paediatrics
Obstetrics and Maternity Services	Community Midwifery
Neonatal Unit	Gynaecology
HIV Service	Breast Service
Termination of Pregnancy	Fertility Service

CORPORATE SERVICES (25)

Corporate Governance and Foundation Trust Membership Office	Information Technology
Finance and Procurement	Informatics
Clinical Coding	Information Governance
Programme Management Office	Medical Records
Quality and Safety	Equipment Services
Corporate Nurse Management (including End of Life Care)	Switchboard
Chaplaincy	Strategy and Partnerships

Bereavement Office	Communications
Infection Prevention and Control	Human Resources
Complaints and Patient Experience	Learning and Development
Safeguarding	Occupational Health
Hotel Services	Health and Safety
Estates	

Appendix Two

Quality Account Commentary for Wirral University Teaching Hospital provided by Healthwatch Wirral CIC
June 2021

'Foundations of Quality Improvement should always have what patients tell us about their treatment and care at the heart of everything, as a system, that we plan and do. We must be able to evidence that all actions and decisions made come back to this, making certain that everyone feels respected, involved and valued at each and every part of the journey. We should all feel confident that we are either giving or receiving quality care.'

Healthwatch Wirral, Age UK Wirral, NHS England and ECIST, Wirral System

Healthwatch Wirral would like to thank Wirral University Teaching Hospital for the opportunity to comment on their Quality Account for 2020/2021.

Quality Priorities for 2021-2022

Breakthrough Quality Improvement Priority: Deteriorating Patients

Quality Improvement Programmes: Falls, Infection Prevention and Control, Tissue Viability and Nutrition and Hydration

Quality Improvement Priorities and Programmes for the Year 2021-22 were noted.
The account detailed the priorities with clear rationale and outlined how the Trust aims to achieve them.

Patient Safety Insight:
It was pleasing to note that the Trust is developing further how they consider the current intelligence they have from complaints, claims, incident reporting, patient and staff feedback, clinical audit and mortality reviews and how they will use this to inform and plan their safety improvement work in the future.
Healthwatch Wirral look forward to working with the Trust to support these plans and ensure that staff and patient voices are heard.

Review of Priorities for Improvement 2020 – 2021

It was disappointing to read that much of the improvement work planned was paused during the year due to the Covid 19 Pandemic and that the target for achieving zero tolerance in reducing hospital acquired infections (Hospital Acquired MRSA) and zero tolerance in Pressure Ulcers (Hospital Acquired Category 3 and above) were not met.
However, it was positive to note that a full review of cases had been undertaken to establish learning and ensure key actions are taken to prevent future occurrences of MRSA and that the Trust had appointed a Lead Tissue Viability nurse, had expanded the team and provided a significant number of senior nurses with specialist Tissue Viability training.

Healthwatch Wirral look forward to receiving quarterly updates in each of these priorities.

National Audits

It was disappointing that the Trust were only able to participate in 60% of the national clinical audits due to either suspension of the remaining audits, or the impact of pressures arising from the COVID-19 pandemic within the Trust.

Healthwatch Wirral noted the outcomes, actions and key successes reported and look forward to seeing the results of the National Audit of Care at the End of Life (Suspended in 2020 due to COVID pressures) which is due to recommence in 2021-22.

Care Quality Commission (CQC) Inspection Report 31 March 2020

It was reassuring to read that the Trust has continued to make significant progress in both the response to the requirements and recommendations made within the report and that 70% of the overall action plan has been achieved with all remaining actions in progress.

Healthwatch Wirral congratulate the Trust in achieving an 'Outstanding Practice' rating from the CQC as their inspection identified the Trust's 'Keep it Simple' campaign as an area of outstanding practice.

Never Events

It was disappointing that one Never Event was reported under the category of wrong site surgery. However, the Never Event underwent a full investigation by the Trust and learning has been disseminated and discussed through the appropriate routes.

Freedom to Speak Up

It was positive to note that 3 FTSU Guardians are currently in post along with a network of 18 FTSU Champions whose role is to work within their service areas, supporting the FTSU Guardians and promoting and encouraging staff to speak up.

However, it was disappointing to read that attitudes and behaviours continue to be the most reported theme with 25 concerns linked with patient safety, compared to 12 last year.

Staff Survey

It was pleasing to read that the response rate from staff had improved from the previous year and that the Trust received a stable set of results during a very challenging year, with no theme areas declining significantly.

Core Indicators and Overview of the Quality of Care and Performance

These were noted along with any actions to improve and progress updates**.**

Quality Strategy Campaigns

Healthwatch Wirral acknowledge the decision to suspend requirements of the Quality Strategy whilst the Trust focused its resources on maintaining patient, staff and public safety and quality during the COVID-19 pandemic. We look forward to receiving quarterly updates on the campaigns, particularly the ones with red or amber status.

Healthwatch Wirral noted the extensive measures taken to maintain safe service delivery during the Covid 19 pandemic and were pleased that this was the Trusts overriding focus in 2020-2021

We would like to congratulate the Trust on the launch of a Covid Vaccination Hub providing vaccinations for the community of the Wirral.

Healthwatch look forward to continuing to work with the Trust to support the implementation of the Quality Account and strategic plans.

Elaine Evans

Project Officer - Healthwatch Wirral
On behalf of Healthwatch Wirral

Appendix Three

Statement from NHS Wirral Clinical Commissioning Group
Quality Account 2020/21

NHS Wirral Clinical Commissioning Group (CCG) is committed to commissioning high quality services from Wirral University Teaching Hospital NHS Foundation Trust. We take seriously our responsibility to ensure that patients' needs are met by the provision of safe, high quality services and the views and expectations of patients and the public are listened and acted upon.

This year has seen an unprecedented challenge on all NHS providers in response to the global pandemic and we would like to acknowledge the significant steps that have been taken by Wirral University Teaching Hospital NHS Foundation Trust to ensure high quality care during this year.

We welcome the opportunity to comment on this account and believe it reflects accurately quality performance in 2020/21 and sets out forthcoming priorities for 2021/22.

We acknowledge that there have been barriers to delivery of some of the planned quality priorities such as the national pausing of the Friends and Family Test (FFT) and unexpected priorities created by the pandemic response have seen a pausing of the requirements of the quality strategy. This has led to the partial year FFT position slightly below target and whilst work has occurred to reduce hospital acquired pressure ulcers this has not reached the target position.

The progress made with regards to falls prevention and nutrition and hydration are clearly highlighted and represent positive improvements in patient safety. It is also important to note the improvements in infection prevention and control as identified during the unannounced CQC focus inspection and with the account noting the reduction in both Gram negative Infections and Clostridium Difficile Infections. The increase in MRSA cases, to 2, during 2020/21 has been reviewed and actions required will be monitored through the system wide Infection Prevention and Control meetings.

It is assuring that the quality priorities for 2021/22 continue to focus on key areas of patient safety; to deliver on the ambitions that were not realised in 2020/21, to ensure sustainability of those ambitions that were realised and also include new areas of focus. The account also acknowledges the focus required on recovery of the trust elective programme.

Whilst patient experience priorities have not been highlighted within the quality account for 2021/22, this remains a key measure of high quality care that will be monitored and discussed through the existing Clinical Quality and Performance Group meetings between the CCG and the Trust. The CCG continue to work with the Trust to seek a wide range of patient experience insight to continually improve quality.

The CCG feels it is important for the trust to note that there was one Never Event during the year, which is a decrease from two Never Events during 2019/20. The Never Event has been fully investigated by the trust and learning has been discussed through the appropriate routes with the CCG. Further detail about the learning from these Never Events and other Serious Incident investigations is discussed regularly with the CCG to support a learning culture. NHS Wirral CCG will continue to work in partnership with the Trust to assure the quality of services commissioned for the population over the forthcoming year.

Dr Paula Cowan
Chair
30th June 2021