Wirral University Teaching Hospital (WUTH) Quality Account 2022/23

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1 Part 1: Foreword

Foreword to the Wirral University Teaching Hospital Trust Quality Accounts
Janelle Holmes, Chief Executive Officer

The quality of our patient care remains the top priority for the Trust, in a year where we have continued to face sustained pressures; driving recovery of the elective care programme to reduce the backlog of patients awaiting treatment following the impact of the COVID-19 pandemic alongside significant demand for urgent and emergency care. This has also been a year with unprecedented levels of industrial action across the NHS and as a Trust we have extensively planned for and mitigated risks to ensure quality and patient safety throughout.

Whilst there has been challenge to deliver high quality care and treatment during this time of pressure, this has not prevented the Trust from driving forward innovation and improvement to provide our patients with the best care that we can. This has included development and launch of the Cheshire and Mersey Elective Surgical Centre at Clatterbridge, providing increased theatre capacity for patients in Wirral as well as across Cheshire and Merseyside. There has also been significant progress in the Urgent and Emergency Care Upgrade Programme, which is expected to complete in 2025.

Whilst this quality account notes that our quality priorities have not been fully achieved in year, it recognises that progress has been made and the drive for improvement will continue into 2023/24. We are truly grateful for the support of our colleagues internally and externally in helping to shape the quality priorities for the forthcoming year and are determined to continue to improve our joint working across Wirral and the wider Cheshire and Merseyside system to collaborate in quality improvement.

We are proud of our strive to enhance clinical effectiveness within the Trust and the account clearly demonstrates our commitment to clinical audit and research to support further progress toward clinical excellence.

The greatest asset of any healthcare provider is our workforce. This quality account also explores our workforce support. It is positive to see the strengths of our freedom to speak up offer and that most colleagues who utilise this service do so without anonymity demonstrating our progress towards just and learning culture. The NHS Staff Survey is a key tool to support the Trust to get it right for our workforce. We have seen a response rate of 43% (3,135 responses) which reflects the engagement of our staff. The results of the staff survey have been mapped to the People Strategy and are being used to inform priorities for next year.

The quality account identifies two Never Events, whilst a reduction from the previous year, the Trust aims for zero. Both Never Events have been investigated and these Quality Governance processes have enabled us to learn from the events.

The forthcoming year is an exciting period for the Trust building upon the implementation of the Quality and Patient Safety Enabling Strategy during 2022/23, the delivery of this Strategy over the next 3 years will support a more intelligent and learning organisation, utilising the insight through; data, expert clinical knowledge and most importantly the engagement with our patients and public to deliver sustainable and measurable improvements in quality.

Whilst all of the Trust enabling strategies will support better care for our patients, it is important to note the Research and Innovation Strategy described in the account. With clear recognition that research active hospitals have better patient outcomes, we are pleased to detail the ongoing research provided by the Trust.

Janelle Holmes
Chief Executive Officer

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

(a) Update on priorities for 2022-23.

The improvement priorities identified within last year's Quality Account were:

1. To improve Patient Safety, we will reduce hospital acquired infection rates with a targeted reduction in those that are part of the quality requirements for NHS Trusts and NHS foundation trusts as determined by NHSE/I. This requires reduction in:
    - the number of patients who are diagnosed with *Clostridioides difficile* (*C. difficile)*
    - the number of patients diagnosed with Gram-negative bloodstream infections (*E Coli*, *P. aeruginosa* and *Klebsiella spp)*

2. Management of the Deteriorating patient (as part of Harm free care): To continue a structured Quality Improvement (QI) programme to improve the early recognition, escalation, and response to the deteriorating patients. with successful impact measured through the following process and outcome data:
    - Extend the QI 2021 /22 programme. Specifically, to increase number of QI pilot wards from 4 to 8, inclusive of AMU[1].
    - NEWS2[2] compliance to policy (All scores)
    - MET [3]Call performance – to ensure that we have the right plan in place.
    - Compliance with fluid balance

3. Restore and recovery: to increase access and availability to outpatient appointments:
    - We will move 5% of all outpatients (new and follow up) appointments to Patient Initiated Follow Up appointments by March 2023.
    - Patient satisfaction.
    - Reduction in waiting times

Progress in relation to these 3 priorities areas is described below:

1. **To improve Patient Safety we will reduce hospital acquired infection rates with a targeted reduction in those that are part of the quality requirements for NHS Trusts and NHS foundation trusts as determined by NHSE/I. This requires reduction in:**
    - **the number of patients who are diagnosed with *Clostridioides difficile* (*C. difficile)***
    - **the number of patients diagnosed with Gram-negative bloodstream infections (*E Coli*, *P. aeruginosa* and *Klebsiella spp)***

Not Achieved - We did not achieve the improvement target and this work is ongoing:

The Health and Social Care Act 2008 (Regulated Activities) revised 2022, outlines what registered providers in England should do to ensure compliance with the registration requirement at regulation 12(2)(h) of the regulations. This includes 'assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated'.

Good infection prevention control (IPC), including cleanliness and prudent antimicrobial stewardship (AMS), is essential to ensure that people who use health and social care services receive safe and

[1] Acute Medical Unit
[2] National Early Warning Score
[3] Medical Emergency Team

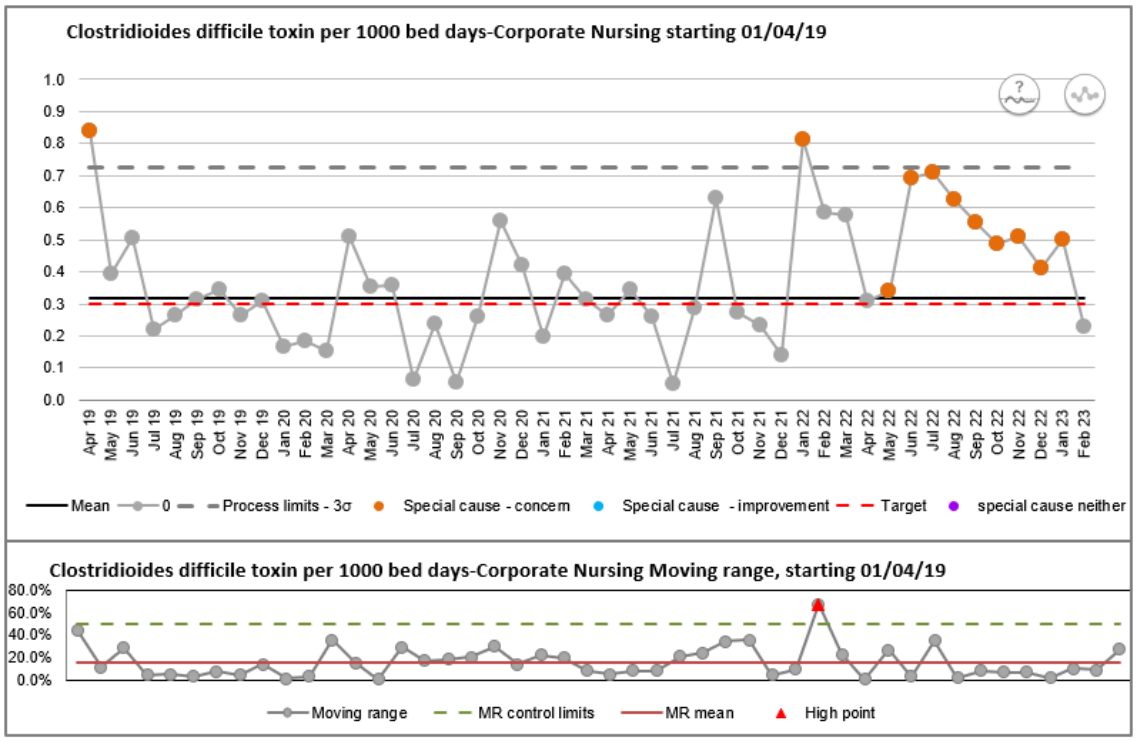
effective care. Effective prevention of infection must be part of everyday practice and be applied consistently by everyone. It is also a component of good antimicrobial stewardship as preventing infections helps to reduce the need for antimicrobials. Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are set up and maintained.

The NHS Standard Contract 2022/23 includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of both *Clostridioides difficile* (CDI) and of Gram-negative bloodstream infections (GNBSI) to threshold levels set by NHS England.

This is in recognition that Infections can cause delayed recovery, prolonged hospitalisation and may cause harm or death, particularly in vulnerable patients. Reducing hospital acquired infection reduces the need for antimicrobials and further promotes patient safety by reducing extended lengths of stay, which supports patient flow throughout the organisation.

Improvement in infection control procedures to achieve the set threshold levels for both CDI and GNBSI objectives also promotes a reduced transmission of other infections within the hospital, including Influenza, Norovirus and COVID 19.

Following a significant rise in CDI in June 22, a CDI Trust wide Improvement plan was developed with quarterly updates reported via IPCG, PSQB, Trust Quality Assurance Committee and the Trust Board to monitor its progress. The hard work of the teams and a focus on the initiatives within the improvement plan had a beneficial impact on patient safety, which is reflected in the downward trend in the number of infections reported each month and a positive reduction in CDI in Q4. Whilst recognising that the CDI annual objective has been a challenge to the organisation, there is no longer a statistically significant variance from other providers in the northwest.



Clostridioides difficile													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20*	19	9	11	5	6	7	8	6	7	4	4	3	89
2020/21	6	5	5	1	4	1	5	10	8	4	7	6	62
2021/22	5	7	5	1	6	13	6	5	3	18	12	13	94

Trajectory 2022/23	6	6	6	6	6	6	6	6	6	6	6	6	72
Actual 2022/23	7	8	16	17	15	13	12	12	10	13	5		128

A review of antibiotic guidelines was completed to ensure that antibiotics with higher-risk for *C.difficile* are not recommended first-line unless there are specific reasons. Scrutiny has highlighted the complexities of CDI cases and whilst antibiotics cannot be said to cause all episodes of CDI it is certainly a contributory factor. Good antimicrobial stewardship practices are a vital part of reducing the spread of multi drug resistance organisms (antimicrobial resistance (AMR)).

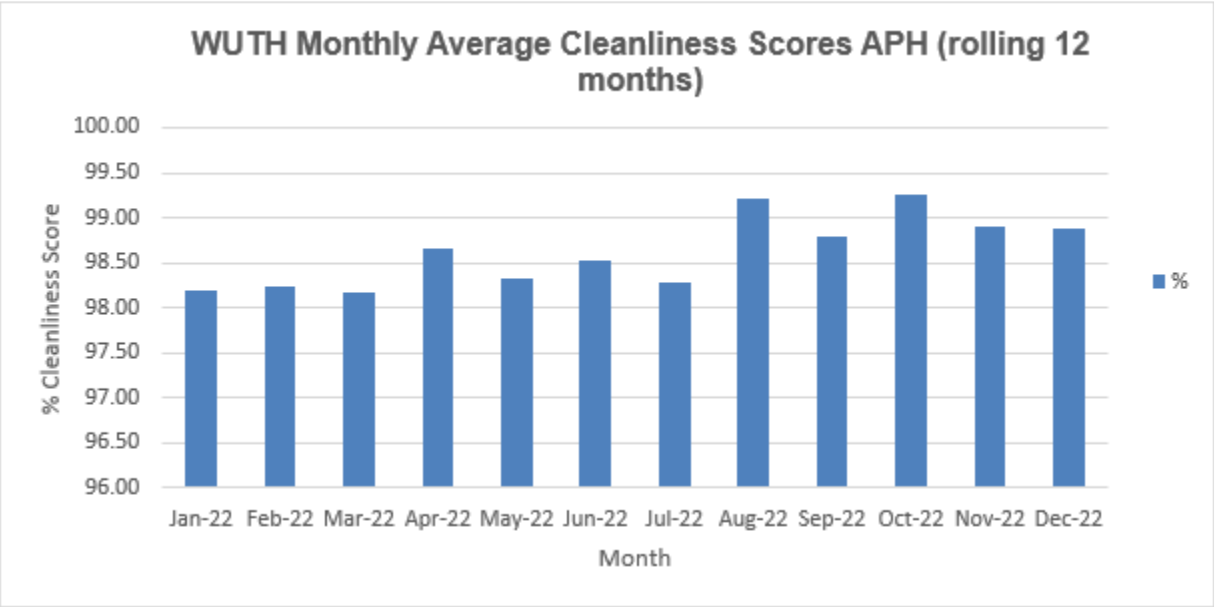
ASPIRE Quality indicators (Trust wide)		Q3
Documentation of indication for antibiotics on prescription	G ≥95% A 85-94% R ≤84%	97%
Stop / review date on antibiotic prescription	G ≥95% A 85-94% R ≤84%	98%
Compliance with antibiotic formulary	G ≥95% A 85-94% R ≤84%	100%
Antibiotic clinical review undertaken within 72 hours of initiation	G ≥95% A 85-94% R ≤84%	96%

The NHS Standard Contract for 2022/23 specifies that the Trust reduce consumption of broad-spectrum antibiotics (measured in DDDs/1000 admissions) by 4.5% compared to calendar year 2018. The table below demonstrates that this target was achieved, with rate of consumption of broad-spectrum antibiotics reduced by 9% in 2022/23 to date when compared with 2018.

National antibiotic consumption target:	**Baseline**	**Target by Q4**	**April 22 – Dec 22**
Reduce consumption of broad-spectrum antibiotics from WHO "Watch" and "Reserve" categories (DDDs/1000 admissions reported quarterly) compared to calendar year 2018.	2399	2291 G ≥4.5% reduction A 1-4.5% reduction R <1% reduction	2188 (9% reduction)
Reduce consumption of intravenous antibiotics by 1% compared to previous year (DDDs/1000 admissions reported quarterly)	1148	1137 G ≥1% reduction A 0-1% reduction R <0% reduction	1131 (1.5% reduction)

Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) is also relevant to IPC and requires healthcare premises to be clean, secure, suitable, and used properly. Stipulating that a provider keeps standards of hygiene appropriate to the purposes for which they are being used. Furthermore, it states that NHS bodies and independent providers of healthcare and adult social care in England must adequately resource local provision of cleaning services. Providers are required to have a strategic cleaning plan, clear cleaning schedules and frequencies so that patients, staff, and the public know what they can expect.

The new 'National Standards of Healthcare Cleanliness 2021' were introduced into the Trust in 2022/23. The standards include monthly mandatory efficacy audits.



In addition to this the facilities team in collaboration with the IPC team developed their own improvement initiatives as part of the overarching CDI plan, introducing targeted cleaning using a risk assessment approach and training and development of their staff with a focus on IPC.

Keeping the number of Gram-negative bloodstream infections within the annual threshold has also been demanding and once again has seen the same upward trend in other organisations in the Northwest.

A multi-disciplinary program of work was commenced, with a focus on education around clinical skills and aseptic non-touch technique (ANTT) training, and urinary catheter care, both focused on competency and assessment for all clinical staff undertaking clinical procedures to support the prevention of device-associated infections, alongside these initiatives the launch of the 'Gloves are off' campaign focused on improved hand hygiene to reduce the incidence of cross infection which was accepted well by all the divisions within the Trust, once again focusing on improving patient safety.

- *E coli* bloodstream infection threshold – no more than 56 cases at end of year

E.coli bacteraemia													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
Trajectory 2022/23	5	5	4	5	5	4	5	5	4	5	5	4	56
2021/22	4	4	7	3	3	5	4	4	6	5	6	8	59
2022/23	8	4	9	12	10	6	5	5	11	5	6		66

- *Pseudomonas Spp* bloodstream infection threshold - no more than 9 cases at end of year

Pseudomonas bacteraemia													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
Trajectory 2022/23	1	1	0	1	1	0	1	1	0	1	1	1	9
2021/22	1	0	0	0	2	3	0	1	0	0	0	1	8
2022/23	0	0	0	0	1	0	0	1	1	3	1		7

- *Klebsiella* bloodstream infection threshold - no more than 19 cases at end of year

Klebsiella bacteraemia													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
Trajectory 2022/23	2	1	2	1	2	1	2	1	2	1	2	2	19
2021/22	1	3	4	1	3	0	3	2	2	2	1	3	25
2022/23	0	4	1	3	6	3	2	4	5	2	2		32

2. **Management of the Deteriorating patient (as part of Harm free care): To continue a structured Quality Improvement programme to improve the early recognition, escalation and response to the deteriorating patients. with successful impact measured through the following process and outcome data:**

   - **Extend the QI 2021/22 programme. Specifically, to increase number of QI pilot wards from 4 to 8, inclusive of AMU.**
   - **NEWS2 compliance to policy (All scores)**
   - **MET Call performance – to ensure that we have the right plan in place.**
   - **Compliance with fluid balance**

Partial Achievement – Management of the Deteriorating Patient has been of significant focus during 2022/23. The partial achievement will be discussed in relation to each of the measures indicated.

The Quality Improvement pilot roll out has not been fully extended to 8 pilot wards during 2022/23, however at the end of the year is active on 7 wards including AMU. This has specifically been impacted upon by vacancies and absence within the Quality Improvement resource within the Trust. This has resulted in slower progress than anticipated.

Compliance with NEWS2 policy has been monitored through 2 main data sources (clinical audits and data from electronic patient records (EPR)), the data below is from regular audit data completed through the year. It is acknowledged that this data is a small sample audit and so during the year actions have been taken to move towards a direct extract from the EPR system. The data from the EPR system has included all patients, however, has not been developed sufficiently to support exception reporting and alignment of patients undergoing continuous monitoring. The data available has demonstrated progress through the year, however the proposed priorities for 2023/24 will include improved data capture to provide assurance across all patients rather than small sample audits.

Compliance has been seen in relation to several of the key performance indicators:

Measure	**Tolerance**	**Audit Data (Tendable) Year 22/23**
NEWS2 score within 30 minutes of arrival	90%	88.2%
NEWS2 score repeated at policy frequency for a previous score of 0	90%	96.3%
NEWS2 score repeated at policy frequency for a previous score of 1 – 4	90%	75.4%

NEWS2 score repeated at policy frequency for a previous score of 5 – 6	90%	90%
NEWS2 score repeated at policy frequency for a previous score of 7+	90%	97.3%

MET Call compliance is measured against a 15-minute window from call to response. This data is reported through audits led by the critical outreach team and feeds into the Deteriorating Patient Steering Group. Audits completed for MET calls during December 2022, January 2023 and February 2023 reviewed a total of 140 MET calls and the average response time across all audits was under 3 minutes.

Compliance with Fluid Balance monitoring for patients with a NEWS2 score of 5+ is recorded through the audit data (Tendable[4]) and achieved 82.3% compliance over the year against a 90% tolerance. As above the data capture for this indicator will be improved as part of the 2023/24 quality priority proposals.

3. **Restore and recovery: to increase access and availability to outpatient appointments:**
    - **We will move 5% of all outpatients (new and follow up) appointments to Patient Initiated Follow Up (PIFU) appointments by March 2023.**
    - **We will improve OPD Patient satisfaction.**
    - **We will Reduce OPD waiting times.**

Partially Achieved – We made progress in relation to movement towards PIFU, however did not achieve the in-year target and further work is ongoing:

This quality priority is also a national driver, and the percentage position is monitored via NHS England. The Trust current position for 2022/23 is 1.2%. Whilst the challenging target has not been achieved significant progress has been made.

The Trust has supported 19 Specialties to go live with PIFU in year:

- Community Paediatrics
- Dermatology
- ENT
- Occupational Therapy
- Ophthalmology
- Paediatric Urology
- Paediatric Respiratory Medicine
- Paediatric Cardiology
- Paediatrics
- Physiotherapy
- Respiratory Medicine
- Rheumatology
- Speech and Language Therapy
- Urology

[4] Quality inspection app and platform for health and care settings

- Pain Management
- Upper Gastrointestinal Surgery
- Oral Surgery
- Clinical Haematology
- Audiology

The implementation across these specialties has allowed 7756 patients to be transferred to a PIFU pathway and allowed for increased efficiency in delivery of appointments.

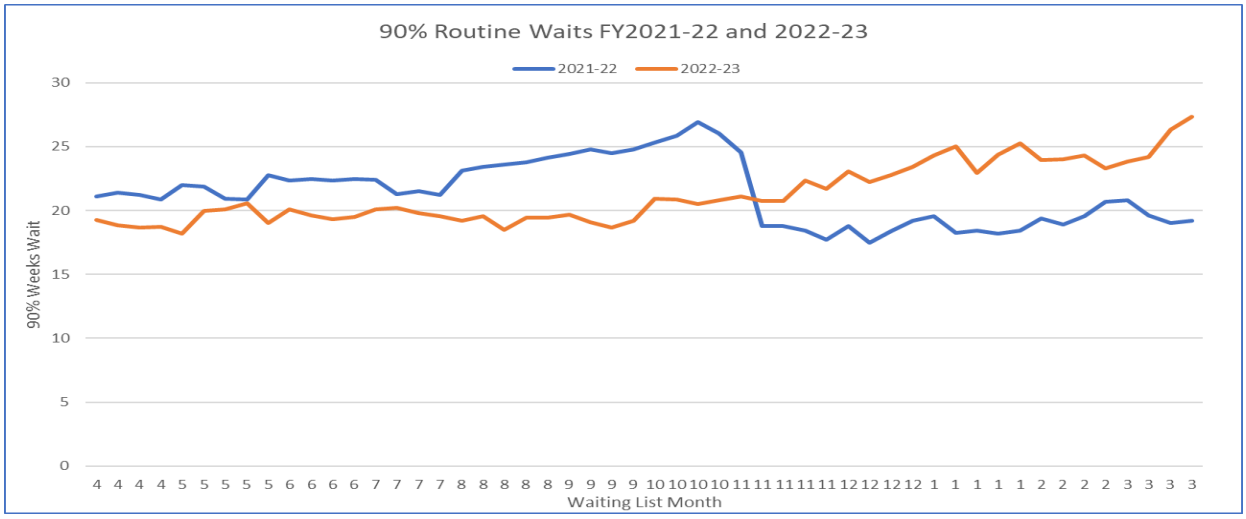
The Trust has plans in place to continue to roll out PIFU to other specialties over the next few months and have received an intelligence summary from NHS England to support efficient improvements in this aim by targeting of 5 specialties where we may expect to see the greatest impact, these are: Physiotherapy, Trauma and Orthopaedics, Respiratory, Gynaecology and Ophthalmology.

Two of the specialties with the greatest potential impact are still to go live with PIFU and will be prioritised. The operational team will continue to work with these specialties to realise further potential in 2023/24.

Patient Experience feedback was a second key indicator of success with regards to this quality improvement. During 2022/23 there has been a successful improvement with the target of 95% or above being achieved for the final 4 months of the year:

Patient Experience Feedback												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
OPD	93.5%	94.3%	93.5%	94.6%	94%	94%	94%	94.2%	95.0%	95.05%	95.01%	95.00%

Outpatient Department waiting times have not seen the intended reduction, however additional unanticipated barriers have been faced due to industrial action. This will continue to be an area of focus moving into 2023/24.



(b) Looking forward to 2023-24.

The Trust improvement priorities for the forthcoming year build upon the priorities from 2021/22 and incorporate key aspects of the Trust Quality and Safety Strategy:

Building on from the work completed during 2022/23 the priorities for 2023/24 have been produced with engagement across both hospital clinical and quality leaders but most importantly support from

a range of external hospital partners. We would like to thank our partners for their input into supporting focus on our quality priorities.

Three areas for priority action in 2023-24:

1. To empower patients by increasing the opportunities to expand their role as partners in their own healthcare. Success of this priority will be measured through:
   - Patient engagement in the promise groups as part of the Patient Experience Strategy
   - Continued roll out of the Patient Initiated Follow Up programme, ensuring patient led decision making about the need for follow up appointments.
   - Increasing the offer of self-medication during hospital admissions, ensuring patient control of regular medication
   - Delivery of a Patient Safety Partner Campaign; Part A Involving patients in their own safety.
   - Engagement with partners to fully understand the barriers to accessing Trust services presented by health inequalities.

2. To improve planning and preparation for safe transfer of care from hospital when a patient's period of inpatient admission is no longer required. Success of this priority will be measured through:
   - Preparation process measures, including; estimated date of discharge, timeliness of TTH[5] medications.
   - Communication measures, including; information for patients throughout their admission, information with healthcare providers post transfer
   - Patient Experience feedback

3. To build upon recent progress and further improve management of the Deteriorating Patient. This is a continued focus moving into 2023/24, however will aim to:
   - Increase the assurance of compliance with NEWS2 by gathering robust and accurate data from the EPR[6] system for all patients.
   - Improving the use of Sepsis Bundle Pathways (Sepsis 6)
   - Improve accuracy of Sepsis coding

The following section includes statements of assurance and details of WUTH National Audits.

Statements of Assurance

During 2022/2023 Wirral University Teaching Hospitals NHS Foundation Trust provided and/or subcontracted the 85 relevant health services

Wirral University Teaching Hospitals NHS Foundation Trust has reviewed all data available to them on the quality of care in all 85 of these relevant health services.

The income generated by the relevant health services reviewed in 2022/2023 represents 100% of the total income generated from the provision of relevant Health Services by The Trust for 2022/2023.

[5] To Take Home medication

[6] Electronic Patient Record

2.1.1 National Audits

During 2022/2023, the Trust participated in 93% 43/46 of national clinical audits and 100% 3 national confidential enquiry reports/ review outcome programmes that it is eligible to participate in, covered by the NHS health services it provides. These are listed below; alongside a summary of what the audit was about and data submission information for each one:

Clinical Audit Programme/ Work Stream	What is the audit about	Data Submission
Case Mix Programme (CMP)	Patient outcomes from adult, general critical care units.	Continuous data collection
Elective Surgery (National PROMs Programme)	Patients undergoing elective inpatient surgery for hip and knee replacement, completed questionnaires before and after their operations to assess improvement in health as perceived by the patients.	Continuous data collection
Emergency Medicine QIP - Pain in children	To improve patient care by reducing pain and suffering, in a timely and effective manner through sufficient measurement to track change but with a rigorous focus on action to improve. The RCEM identifies current performance in EDs against nationally agreed clinical standards and show the results in comparison with other departments.	Oct21–Oct22
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Clinical Audit: Children and young people newly diagnosed with epilepsy and subsequent care for 12 months. 12 months of subsequent care. Organisational audit: on paediatric epilepsy services, focusing on services and workforce at Trust/Health Board level.	Continuous data collection
FFFAP - National Hip Fracture Database	Improves quality of care for hip and femoral fractures, particularly collaborative care.	Continuous data collection
Gastro-intestinal Cancer Audit Programme: National Bowel Cancer Audit	Reviews good clinical care and compares variations, and changes in care over time; and outcomes.	Continuous data collection
Gastro-intestinal Cancer Audit Programme: National Oesophago-gastric Cancer	An audit of the care received by people with oesophagogastric cancer	Continuous data collection
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Uses the information about the deaths of people with a learning disability, aged 4 and over, to improve care and prevent premature mortality.	Continuous data monitoring
Maternal and Newborn Infant Clinical Outcome Review Programme	Using information from lessons learned, to inform maternity care.	Continuous data collection
Medical and Surgical Clinical Outcome Review Programme	End of Life Care	1/3/23 to 31/3/23
NACAP - Adult Asthma Secondary Care	Captures the processes and clinical outcomes of treatment for patients admitted to hospital with asthma attacks.	Continuous data collection
NACAP - Chronic Obstructive Pulmonary Disease Secondary Care	Captures the process and clinical outcomes of treatment in patients admitted to hospital with COPD exacerbations.	Continuous data collection
NACAP - Pulmonary Rehabilitation-Organisational and Clinical Audit	Patients with COPD who attend an initial assessment for PR, aged 35 years or over.	Continuous data collection
National Audit of Care at the End of Life	Comparative audit of the quality and outcomes of care experienced by the dying person and those	June to Oct22

	important to them during the last admission leading to death	
National Audit of Dementia	Looks at quality of care received by people with dementia in general hospitals	Sept22 to Mar23
FFFAP: National Audit of Inpatient Falls	The delivery and quality of care for patients over 60 who fall and sustain a fracture of the hip or thigh bone. Reviews the care the patient has received before their fall as well as the post fall care.	Continuous data collection
National Child Mortality Database	Records comprehensive data on the circumstances of children's deaths, to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.	Continuous data collection
National Diabetes Core Audit	Compares patient care and outcomes against NICE guidelines, to identify gaps or shortfalls that are priorities for improvement	Continuous data collection
National Diabetes Inpatient Safety Audit	Collection of data on 4 key harms that can occur to diabetic inpatients.	Continuous data collection
National Early Inflammatory Arthritis Audit	Aims to improve the quality of care for people living with inflammatory arthritis, over the age of 16.	Continuous data collection
National Emergency Laparotomy Audit	Aims to improve quality of care for emergency bowel surgery patients	Continuous data collection
National Joint Registry	Reports on performance outcomes in joint replacement surgery in a continuous drive to improve service quality, to ultimately improve patient outcomes.	Continuous data collection
National Lung Cancer Audit	Provides information on the process of care and outcomes for patients diagnosed with lung cancer	Continuous data collection
National Maternity and Perinatal Audit	Reviews NHS maternity services: aims to evaluate a range of care processes and outcomes to identify good practice and areas for improvement in the care of women and babies.	Continuous data collection
National Neonatal Audit Programme	Aims to improve care to babies that need specialist care when they are born (born too early, with a low birth weight or have a medical condition).	Continuous data collection
National Ophthalmology Database Audit	Measure and protect patient safety and professional standards by measuring outcomes of cataract surgery.	Continuous data collection
National Paediatric Diabetes Audit	Collects information on the care and diabetes outcomes of all children and young people receiving care from paediatric diabetes teams. The sole aim is to provide information that leads to an improved quality of care for those children and young people living with diabetes.	Continuous data collection
National Perinatal Mortality Review Tool	Available to trusts and health boards to carry out a local review of all perinatal deaths born from 22 weeks' gestation onward	Continuous data monitoring
National Pregnancy in Diabetes Audit	Measures the quality of care received by women with pre-existing diabetes who become pregnant	Continuous data collection
National Prostate Cancer Audit	Measures the quality and outcomes of care for patients diagnosed with prostate cancer in NHS hospitals; supporting hospitals to improve the quality of the care received by patients.	Continuous data collection
NCAP - Myocardial Ischaemia National Audit Project (MINAP)	Monitors the care of STEMI and NSTEMI patients	Continuous data collection

NCAP - National Audit of Cardiac Rhythm Management	Collects procedure information on all patients with implanted devices or receiving interventional procedures for management of cardiac rhythm disorders	Continuous data collection
NCAP - National Heart Failure Audit	Collects data on all patients with an unscheduled HF admission to hospital who have a death or discharge with a coded primary diagnosis of HF	Continuous data collection
NCEPOD - Crohn's Disease	To review of remediable factors in the quality of care provided to patients aged 16 and over with a diagnosis of Crohn's disease who underwent a surgical procedure.	1/9/21 to 30/11/22
NCEPOD - Epilepsy	Highlights the quality of epilepsy care provided to adult patients presenting to hospital with a seizure.	1/4/22 to 30/4/22
NCEPOD - Transition from child to adult health services	Explores the barriers and facilitators in the process of the transition of young people with complex chronic conditions from child to adult health services.	Sample of 7 patients
Paediatric Asthma Secondary Care	Looks at KPI performance for respiratory care in children and young people admitted to hospital with an asthma attack	Continuous data collection
Perioperative Quality Improvement Programme	Measures complications, mortality and patient reported outcome from major non-cardiac surgery. The ambition is to deliver real benefits to patients by supporting clinicians in using data to improve patient outcomes, reducing variation in processes of care and supporting implementation of best practice.	Continuous data collection
Renal Audit - National Acute Kidney Injury Audit	Nationwide collection of AKI warning test scores	Continuous data collection
Renal Audit - UK Renal Registry Chronic Kidney Disease Audit	Looks at care provided to patients with CKD (including people pre-KRT [7]and on KRT) at each of the UK's adult and paediatric kidney centres against the UK Kidney Association's guidelines.	Continuous data collection
Respiratory Audit - Adult Respiratory Support Audit	To capture data on patients outside critical care that have required respiratory monitoring or intervention (i.e. either admitted to an acute respiratory support unit or treated in another ward setting with NIV/CPAP/HFNO), with a view to better understanding variations in clinical practice and outcome.	1/2/23 to 31/5/23
Sentinel Stroke National Audit Programme	To improve the quality of stroke care	Continuous data collection
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Produce recommendations in annual reports based on information received from adverse events and reactions related to transfusion	Continuous data collection
Society for Acute Medicine Benchmarking Audit (SAMBA)	Collects information on unit structures, as well as helping us understand more about your acute medicine workforce	23/6/22 to 14/7/22
Trauma Audit and Research Network (TARN)	Provide information to help Doctors, Nurses and Managers improve their services dealing with children and adults admitted with injury in trauma units; reduce people dying or becoming disabled after injury.	Continuous data collection
UK Parkinson's Audit	Measures the quality of practice delivered specialists who care for people with Parkinson's, to trigger service improvement plans.	1/5/22 to 30/9/22

[7] Kidney replacement therapy

All national clinical audit reports published by the provider, are reviewed at a local level. Listed below are actions the Trust plans to take to improve the quality of healthcare provided:

Audit Title	Outcomes /Action
Case Mix Programme	Majority of quality indicators (8/11) fall within the expected predicated range. Trust is a negative outlier for the following: • Bed days of care post 8-hour delay • Bed days care post 24-hour delay Key Action: To be discussed at Trust wide delivery group.
National Paediatric Diabetes Audit	Key Successes • Median HbA1c[8] improved from 63.5 to 62.8 mmol/mol • Marked improvement in key care processes from previous year – overall completion rate above national average • Additional health checks above national average despite Covid restrictions • 100% compliance with screening bloods and carb counting at diagnosis • Dietetic support and psychological screening –above national average • Reduced microalbuminuria prevalence rates • Reduced emergency hospital admissions Areas for improvement • Worsening deprivation profile • Higher rates of obesity and high BP – need closer monitoring • Low real time CGM[9] and pump use Key Actions • Consider expansion of psychology services • Pump start marathon aided by technology bid funding from NHSE • Consider longer clinic appointments. • Consider diabetes educator appointment • Capacity/demand review and business case
National Perinatal Mortality Review Tool	All cases reviewed within MBRRACE[10] timescales
National Emergency Laparotomy Audit	Key Successes • Adjusted mortality 4.4% compared to national mortality of 8.7% • Pre op risk assessment undertaken 87% (86% nationally) • Arrive in theatre appropriate to urgency (89% Vs 71%) • Consultant anesthetist and surgeon present in theatre with risk of death > 5% 100% (Vs 90%) • Frailty assessment by geriatrician 60% vs 30% nationally Areas for improvement • Reduction in CT reported before surgery 45% (Vs 58% nationally) • Reduction in high-risk case admitted to crit care 81% (Vs 79% nationally and 87% locally) • Timely antibiotics administration (within 1 hour) 23% vs 21% nationally • Median LOS in hospital 13 days vs 10 nationally Key Actions • Continue to develop POPs[11] geriatrician service- new BPT[12] targets incoming (>40%) • Liaise with radiology department regarding CT reporting- resource allocation (national shortage of radiologists) • Emphasise importance of timely Antibiotics in ED • Continue development of local NELA[13] pathways and MDT[14] relationships

[8] Average blood glucose sugar level

[9] Continuous glucose monitor

[10] Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

[11] Perioperative care for older people undergoing surgery network

[12] Best practice tariff

[13] National Emergency Laparotomy Audit

[14] Multidisciplinary team

National Early Inflammatory Arthritis Audit (NEIAA)	• Key Successes • -% with an agreed treatment target-above target • -% given contact details for advice line -above target Key Concerns • % patients referred within 3 working days – below target • % patients seen within 2 weeks – below target • % patients started on DMARD[15] within 6 weeks – below target Key Actions • Improve EIA triage process • Recruitment into Consultant and nursing staff to ensure timely review and treatment.

Local clinical audits were also reviewed during 2022/3 with the following outcomes listed below and intended actions to improve patient care:

Audit Title	Outcomes & Actions
#NOF Block Audit	Key Successes • A&E blocks for #NOF[16] Areas for improvement • Assessment of the benefits of local anaesthetic agents for hip fractures. • Limited evidence for use of continuous nerve block techniques in UK practice, which can delay remobilisation. Key Actions • Review nerve blocks provided in ED and efficacy in providing pre-hospital analgesia. • Use of femoral or fascia iliaca blocks • Review use of Ultrasound-guided placements to increase adequacy of analgesia. • Routine use of peripheral nerve blocks to supplement general or spinal anaesthesia.
12 week follow up chest X-rays of previous COVID-19 pneumonia inpatients.	Areas for improvement • Patients having a follow up CXR[17] within the recommended time frame. Key Actions • Investigate potential for text reminder messages for plain film radiography patients
2-week rule CT scans ordered by GP to assess for pancreatic cancer- are they meeting the criteria for referral?	Areas for improvement • Scans not performed within 2 weeks of request. • Scans were not reported within 2 weeks of the scan. • Referrals not meeting NG12 criteria. Key Actions • Review findings with key stakeholder and create an action plan.
2WW Neck Lump Clinic Audit	Key Successes • Good response to 2WW[18] referrals to APH ENT for neck/thyroid/salivary gland lumps • Cancer pick up rate • Rate of patients who had cancerous neck lumps had USS[19] ready prior to clinic • Appropriateness of referrals • Time to diagnosis

[15] Disease modifying antirheumatic drugs
[16] Fractured neck of femur
[17] Chest X rays
[18] 2 Week Wait
[19] Ultrasound scan

	• Time to treatment Key Actions • Review process of patients with USS Neck; vetting tool; referral time. • Review process of downgrading eligible patients for the 2WW pathway • Triaging of referrals • Appropriate scanning of patients, avoid repetition.
A quality assurance project to assess the quality of MRI scan requests for patients with clinically suspected osteomyelitis of the foot/ankle who have an ulcer which is deemed to be origin of the infection	Areas for improvement • MRI scan requests for patients with infected foot/ankle/suspected osteomyelitis had inadequate description of the site ulcer/examination site of concern. Key Actions • Undertake teaching sessions for general medical/diabetic team.
A review of the histopathological reporting of prostate core biopsies	Key Successes • Adherence to microscopic core data items • Negative cores identified were commented on for number of cores involved by HGPIN[20], coded appropriately as per SNOMED[21] • ASAP cores identified during audit - coded appropriately as per SNOMED Key Actions • Consensus meeting between the uropathologists to agree upon a standardised reporting approach to prostate core biopsies • A proforma / synoptic on Cerner that is inclusive of the core dataset items, in line with other cancer reporting • Re-audit of the data over a 6-month period following the implementation of one of the aforementioned measures • Development of an audit tool in order to streamline the approach for future auditing of prostate core biopsies
Agreement of POCT obtained cLiat Covid-19 results on patients admitted to APH compared to Microbiology Main Laboratory-July 2022	Key Successes • Alignment between POCT[22] and micro lab results • C19 Positivity rate improvement.
Wi-Fi connectivity Status of WUTH Nova statStrip Ketone meters	Key Successes • Ketone meters Wi-Fi connectivity. Areas for improvement • Some ketone meters lost Wi-Fi connectivity and lost the required Wi-Fi settings. Key Actions • Completion of Nova incident form submitted to Nova Biomedical • Ensure connectability through intranet cable. • Re-configure new meters.
Anaesthesia Documentation (WUTH)	Key Concerns • No standard chart • Software fault in pre-execution workaround • Documentation of actions Key Actions • Review standard chart and non-compliant macro's • Create core dataset in line with standards
Anaesthetic Management of Neck of	Key Successes • Improvement in use of TXA[23] Areas for improvement

[20] High-grade prostatic intraepithelial neoplasia

[21] Systematized Nomenclature of Medicine Clinical Terms

[22] Point of care testing

[23] Tranexamic acid

Femur Fractures Reaudit	• Low number of Haemacues performed • Cases of hypotension Key Actions • Create guidance for post op Hb monitoring • Promote awareness intra-operative hypotension risks • Review weight based TXA dose
Assessment of the management of hypercalcemia & hyperparathyroidism	Key Concerns • Variation in practice Key Actions • Share findings and circulate guidance
Assurance that patients who are referred for ultrasound of the axilla are imaged in the correct department	Key Successes • Most cancellations for patient scans were appropriate Areas for improvement • Few patients scanned in error Key Actions • Create SOP[24] • Re-audit
Audit of IV antibiotic prescriptions expiring earlier than intended over a single weekend	Key Successes • IV antibiotics stopping earlier than intended has significantly reduced • IV antibiotics stopping in the first 3 days of treatment has also reduced Areas for improvement • Incidents of antibiotic prescriptions stopping earlier continue to occur, albeit at a lower rate. Key Actions • Communicate findings widely throughout the Trust via the communications team. • Liaise with CDDA to ensure that The Antimicrobial Stewardship mPage is redeveloped to support the quality of antimicrobial reviews
Audit of Nephroureterectomies	Key Successes • Agreement between pre and post operative diagnoses of urothelial carcinoma (TCC) in nephroureterectomy specimens seen in 31/37 specimens. • Compliance with RCPath[25] dataset Areas for improvement • Area for improvement identified in RCPath dataset to improve recording of associated CIS[26]. Key Actions • Feedback to histopathology, radiology and urology departments with reflective discussion on non-compliant areas • Improve report coding – “nephroureterectomy” • Improve specific dataset requirements – associated CIS • Reaudit
Management of patients presenting with cardiac chest pain	Key Successes • Readmission rates for patients were low, indicating clinicians are reaching the correct diagnosis on initial admission. Despite the use of the pathway not being documented, clinicians are still requesting cardiology reviews where relevant and prescribing anticoagulation. Areas for improvement • The HEART, GRACE and CRUSADE scoring systems recommended by guidance in the pathway had a low usage rate. Key Actions • Presented at AMU teaching. • To complete further study to monitor ongoing usage of CPP to assess whether progress is being made.

[24] Standard Operating Procedure

[25] Cancer datasets

[26] Clinically isolated syndrome

Breast Carcinoma grading audit	Key Successes • Concordance between biopsies and resections • Concordance with standard grade distribution, but apparent over reporting of grade 2. Key Actions • Re-audit with a larger sample size. • Consider a grading exercise using a random set of cases to compare opinions of all team members. • Improve adherence to grading rules
Breast Checklist audit	Key Successes • Compliance of General Brest Checklist use • Compliance of Screening checklist use • Compliance of Localisation checklist use Key Actions • Staff education on the use of checklists, including those for aspirations and FNAs[27], magseeds. • Review the General procedure checklist in relation to its use with stereowires. • Re-Audit
Bronchiolitis in children	Key Successes • Clinical diagnosis • Implementation of supportive care • Significant improvement in utilisation of PIL[28] • Severity of breathing well documented Areas for improvement • Overall severity of illness not graded by clinicians Key Actions • Review local guidance and amend as required
Chest Drain audit	Areas for improvement • Use of checklist on patients receiving a chest drain. • Criteria missing from the Pre-procedure and Procedure Checklists. Key Actions • Review and update checklists on Cerner • Educate staff on Cerner's chest drain checklist – access and completion.
Clinical Authorisation of blood cultures (WUTH)	Key Successes • No Major errors identified in audit. • Blood culture authorisation by BMS[29] staff is safe and efficient. Areas for improvement • Moderate errors identified - not reporting sensitivities on BC isolates; had minimal clinical impact due to all significant positive blood cultures being followed-up. • Minor errors identified - including failure to report temocillin sensitivity on Enterobacteriaceae isolates and failure to report additional sensitivity on a limited number of samples. Key Actions • Findings discussed at LM-CMM meeting and fed back to Senior Biomedical Scientists • Review SOP
Clinical authorisation of results for wounds (WUTH)	Key Successes • No Major errors identified. • Moderate errors identified within acceptable limits Areas for improvement • Minor errors identified Key Actions • Findings shared with key stakeholder • SOP to be reviewed and updated • Reaudit to measure compliance with revised SOP

[27] Fine needle aspiration
[28] Patient information leaflet
[29] Biomedical Scientist

Comparison of bi parametric MRI and Multi para metric MRI in the diagnosis of clinically significant prostate cancer	Key Successes • The addition of the DCE[30] sequence has significantly improved diagnostic accuracy in patients with suspected prostate cancer.
Compliance of standards of practice of initial management of open fractures at the time of presentation	Key Actions • Dedicated upper limb open fractures guidance review • Share findings with key stakeholders • Re audit
Controlled Drugs Audit	Key Successes • Number of areas compliant with standards is the highest score in the last 3 years, as a result of targeted improvement work across the whole trust, with real time feedback underpinned by a variety of education and training sessions, communication, shared learning and support provided by Matrons and pharmacy medicines safety team. Areas for improvement • Some information missing in the CD record books. Key Actions • Improvement work continues to be required to deliver full compliance with the CD regulations consistently in all areas. • Each division has their own Controlled Drug risk with individualised actions, led by the ADNs[31].
Critical Care team - Gloves QI Project	Areas for improvement • Necessity of glove use • Lack of hands gelled or washed after glove removal • Risk of cross-contamination observed Key Actions • Education and reaudit
CT WHO checklist audit	Key Successes • Majority of criteria achieved 100% compliance • Compliance of the checklist completion checked and signed. Areas for improvement • 2 criteria achieved less than 100% complaint (88% compliance) - silence and Distractions. Key Actions • Results feedback to CT team at CT team meeting • Create notices to display on external doors to discourage unnecessary distractions/interruptions. • Encourage medical staff to leave messages which can be dealt with after patient lists, where possible. • Rolling prospective audit to be continued
CVC insertion checklist	Areas for improvement • Some patients who had a CVC[32] line inserted on critical care did not have the checklist completed. Key Actions • Present at audit day. • Add LocSIPPs[33] to audit doctor induction programme
Developing a framework to align training and development with career progression and succession planning	Key Successes • Identified areas for improvement in training and education, support during career progression, succession planning and meeting objectives for service improvements. Areas for improvement • Time limitations within Teams • Perceived lack of support from senior staff and management • Lack of clear identification of training needs

[30] Dynamic contrast enhancement

[31] Associate Director of Nursing

[32] Central venous catheter

[33] Local Safety Standard for Invasive Procedures

	• Irregularity and in-equitable access to training Key Actions • Feedback results to Senior Leadership Team • The action plan will form part of the directorate strategy plan.
Documented Review of Orthopaedic OPD X-rays	Key Successes • 100% compliance with required legislation and documentation in patient notes - requested images have been reviewed and actioned, in Orthopaedics & Max Fax clinics. Key Actions • Re-audit in 3 years
Efficiency of shoulder rotator cuff injury management in patients referred from ED to physiotherapy	Key Successes • 29% patients were offered appointments with physiotherapy within 14 days of referral from ED. • 33.3% patients with suspected FTTs of rotator cuff who could have been suitable for surgical repair, were referred for urgent radiological investigations on the first physiotherapy contact. • 0% patients diagnosed with rotator cuff FTTs or rupture via imaging (who were suitable for surgical repair) were referred urgently to orthopaedics. Key Actions • A new pathway/service introduced and • Reaudit to determine improvement following introduction of new pathway
Emergencies workload and level of supervision in out of hours anaesthetic practice	Areas for improvement • Proportion of weekday and weekend OOH cases is higher than that recommended by RCOA[34]. Key Actions • Ensure electronic booking forms accurately document time of booking to time of arrival to emergency theatre, to identify reason for any delays and improve patient flow.
Establishing a timeframe involving the antibiotic administration, blood cultures collection and obtaining serum lactate in patients with probable sepsis.	Key Successes: • Blood cultures completed for 92% of patients, with coded diagnosis of sepsis indicating that Drs who diagnosed sepsis knew the importance of blood cultures. Areas for improvement • High NEWS score is a useful sepsis alert trigger, which was not used consistently. Key Actions: • Audit complete and presented at AMU teaching Sept 22. Plan to continue teaching sessions and then re-audit for patients in Oct-Dec. • Action plan to reaudit following further teaching re the sepsis bundle. Will be mentioned during handover, AMU teaching sessions and flyers around hospital
Evaluating the use of dedicated evening MRI slot for suspected cauda equine syndrome	Areas for improvement • NICE[35] guidance not always adhered to • Interpretation of urinary difficulty, as per NICE 'Red flag'
Image Deletion re-audit	Key Successes • Images with missing or incorrect annotation reduced. • Reduction in images sent in error. Areas for improvement • Incidents not being logged. • Increase in image deletion requests. • Increases in images being in wrong folder, missing/incorrect markers, wrong patient folder and images flipped. • Missing fields on delete forms. • Overall continued non- compliance with reporting incidents Key Actions • Image deletion requests to be monitored real time • Encourage staff to report incidents.

[34] Royal College of Anaesthetists

[35] National Institute for Health and Care Excellence

	• Staff education on completing forms and checking accession numbers before image capture
Improving the recognition and management of Community acquired pneumonia in the acute medical unit including antibiotic stewardship	Key Successes • Data is regularly collected to highlight improvements that need to be implemented. • Secondary outcomes of investigations used and there was an improvement which is potentially leading to better use of antibiotics during the patient stay. Areas for improvement • Documenting curb scores • Using antibiotics appropriately based on curb scores. Key Actions • To improve documentation of curb 65 and ensure it is documented.
Intubation checklist audit	Key Successes • Checklist compliance for patients intubated on critical care Areas for improvement • Reduction in compliance from November 2021 audit, Key Actions • Present finding at audit day • Add LocSIPPs to audit doctor induction programme
IR WHO Checklist Audit	Key Successes • Compliance in Clear announcement of WHO, all team members being present, accurate documentation and opportunity to ask, Team response to focused silence, distractions, accurate documentation, Checklist read out. Key Actions • Share findings at IR audit day. • Reaudit to include time out and sign out audit
IR(ME)R Employers Procedures compliance - CT	Key Successes • 100% compliance demonstrated in 3 of 4 areas audited - ID, LMP, Dose results. • 95% compliance demonstrated in remaining area (Justification) Areas for improvement • Justification of decisions not recorded on Cerner Key Actions • Reaudit quarterly
IRMER Operator compliance with employer procedures (Q1 & Q2)	Key Successes • 100% compliance with Justification and ID criteria Areas for improvement • Exposure factors and DAP[36] reading criteria's • DAP reading compliance Key Actions • Repeat audit quarterly. • Roll out audit to CT. • Cascade results to staff. • Review audit template tool.
IRMER Operator compliance with employer procedures (Q3 + Q4)	Key Successes • 85%-100% compliance for indicators – Justification and ID (100%), Exposure factors criteria (97.5%), DAP (90%), LMP[37] (87.5%). Key Actions • Quarterly reaudit to monitor compliance. • Audit rolled out to other modalities during 2023
ITU Transfer Checklist Re-audit	Key Successes • 100% Compliance for all indicators

[36] Dose area product

[37] Last menstrual period

Local audit of CT radiographers performing 3-point ID checks on patients attending for a CT scan	Key Successes • 100% compliance.
LOS on Medically optimised patients on orthopaedic wards	Areas for improvement • High level of patients on ward are MOFD[38] awaiting discharge planning • Delays in discharge due to social issues with patients • Inconsistent Cerner documentation of IDT[39] involvement Key Actions • Share findings with key stakeholders and Hip Fracture MDT
Management of trigger digits	Key Successes • Hand therapy/splinting effective (52% improved/resolved without need for steroid injection/surgery). • 71% patients who received steroid injection reported full resolution after single injection. • 100% compliance demonstrated with PLCP[40] guidelines. Areas for improvement • Variation in practice observed (i.e. splint design, length of time splinted for). • Contact with patients varied (1-11 contacts, average = 4). Raises the query if the management of these patients is cost effective. • Some patients referred to GP injection service could have been managed in hand therapy-led injection clinic, which could have reduced waiting times. Key Actions • To review pathway for TrF management development, reduction in therapy contacts and standardisation of splinting practices. • Trial a specific hand therapist led steroid injection clinic.
Massive Hemorrhage Activation Audit	Key Successes • Blood samples were obtained in 98% of cases after activation, ROTEM used in just over 50% of observed cases. • Use of tranexamic acid in 63% of cases, all within 3 hours. • Emergency group O RBC [41]administration - wide variety of emergency v cross matched blood given (46% cross matched, 35% emergency blood, 14% emergency then group specific cross-matched) • Use of RBCs and FFP[42] in a 1:1 ratio in a trauma setting, whilst in a 2:1 ratio in a non-trauma setting Areas for improvement • 49% of FFP units requested were wasted - 79% of those wasted were in obstetrics. Suggesting a majority of cases, only urgent blood transfusion was required, rather than full MHP[43] activation.
MCAS Clinic – Patient satisfaction survey	Key Successes • More than 95% MCAS Clinic patients surveyed • Patients felt listened to and involved in decisions about their care • Satisfaction with their consultation Areas for improvement • More than 60% patients surveyed, did not understand the purpose of the clinic prior to attendance. Key Actions • Complete IST[44] training session with the Primary care clinicians

[38] Medically fit for discharge
[39] Integrated discharge team
[40] Procedures of low clinical priority
[41] O-red blood cell
[42] Fresh frozen plazma
[43] Major haemorrhage protocol
[44] Improving Surgical Training

Minimising Radiation Dose in computed tomography of kidneys, ureters and bladder (CT KUB).	Key Successes • 100% of scans contained the superior border of the kidneys to the symphysis pubis. • Average radiation dose was close to the NDRLs[45] for CT KUB[46]: DLP 290 mGy cm. Areas for improvement • Some scans started above T10, but showed kidneys • Age of radiation of those being scanned. Key Actions • Shared findings with stakeholders including radiographer and radiologist. • Reaudit to assess compliance with accepted practice.
MRI WHO Checklist audit	Key Successes • 100% compliance - Sign in, Additional needs, Patient details, Opportunity to ask questions. Areas for improvement • Reduce compliance - Time out, Archive form in patient notes and Interruptions Key Actions • Checklist updated and approved at Feb Radiology quality meeting. • Results feedback to MRI team, requirement to file checklists in patient notes reinforced. • Re-audits to be undertaken quarterly.
MSCC Compliance Re-audit	Key Successes • No. of pts having investigations and management guided by MSCC[47] coordinator. • Timely prescription of high dose dexamethasone within 24hrs, • All pts referred to SPC[48] for face-to-face assessment. • All pts given clearly documented management plans. • More pts being seen earlier in the admission by a physio. Areas for improvement • Although MRI scans were requested in a timely manner, there were documented delays in achieving MRI within 24hrs due to faults with scanning machines on several occasions. Key Actions • Presented to Acute Oncology team and • Ongoing regular education sessions are planned within the Palliative and End of Life Teams
Nasogastric tube insertion	Key Successes • Compliance rate for patients requiring NGT insertion Key Actions • Present findings at audit day • Add LocSIPPs to audit doctor induction programme
Obstetric and Neonatal Counselling in the Extreme Pre-term	Areas for improvement • Poor use of obstetric antenatal counselling proforma Key Actions • Results presented to key stakeholders for discussion
Paediatric Anaesthetic Parent Satisfaction Questionnaire	Key Successes • Rating of care received, especially how treated by the anaesthetist. • Being able to visit their child in recovery. Key Actions • Develop Preoperative information. • Ensure patients receive written information where relevant. • Improve post op patient reviews. • Availability of post-op leaflets

[45] National Diagnostic reference levels
[46] Kidneys, ureters and bladders
[47] Metastatic spinal cord compression
[48] Specialist Palliative Care

Paediatric tonsillectomy - a day case	Key Successes • Day case patients listed correctly Areas for improvement • Process of discharging day case patient Key Actions • Review listing as per the criteria
Partial Mammography at Wirral Breast Screening	Key Actions • Deliver education session • Reaudit • Share findings with SQAS[49] for Breast
Patient satisfaction Questionnaire 2022 WIRRAL AND CHESTER BREAST SCREENING PROGRAMME	Key Successes • Respondents felt well cared for and were given clear explanations about the mammogram procedure. • Respondents felt appointments suited their requirements in terms of time and venue. • Covid 19 Safety Literature was received by nearly all respondents. • Safety measures used by the screening programme were deemed 'Very good' or 'adequate' by the majority of respondents
Post operative nausea and vomiting: risk assessment and treatment	Areas for improvement • Monitoring of patients that required anti-emetics after discharge Key Actions • Promote the consideration of whether patients require post-operative anti-emetics according to the risk stratification score • Re-audit and include post-discharge satisfaction rates
Practice of managing pre tibial haematomas at WUTH	Areas for improvement • Variable practice • Knowledge of plastics point of contact in region • Long LOS • Patients sent to DNs instead of being managed at bedside Key Actions • Create a standard management pathway and include key stakeholders • Train ED and T&O on call staff to manage patients at bedside
Quality of Recovery Feedback to Anaesthetists	Key Actions • Develop a personalized feedback tool to enable benchmarking and comparison of surgeons with each other.
Radiation awareness amongst Junior Doctors	Areas for improvement • Knowledge of radiation awareness among junior doctors • Awareness of formal legislation regarding radiation doses in diagnostic imaging amongst doctors Key Actions • Raise risk and formalise actions to ensure improvements
Renal Cryoablation at WUTH	Key Successes • Speedy patient recovery, minimal complications and satisfactory early follow-up results • Renal cryoablation service regionally
Review of cancellations of patients with diabetes for surgery	Areas for improvement • 50% of cancellations still waiting at 8 months Key Action • Explore referring into a preop diabetic clinic to reduce wait times
Septoplasty	Key Successes • Rhinologists adherence to guidelines Areas for improvement • Documentation standards • Single surgeon procedures performed Key Actions • Create template of essential points for documenting septoplasty

[49] Screening Quality Assurance Service

The use of PI-RADS v2.1 in pre-biopsy multi-parametric MRI	Key Successes • High quality reports. • Parameters achieved. • Extra-prostatic extension and Neurovascular bundle Key Actions • Feedback findings to reporters. • Re-audit.
Time to surgery in fractured Neck of Femurs - effect on patient outcomes	Key Actions • Ring-fence morning NOF theatre capacity • Additional Pre-Admission location to Handover List • Identification of patients for home discharge post operatively, patients that need early pre-operative optimization. • Reduction of delayed surgery due to pending medical investigations • Create visual prompts for pre-operative management of NOFs. • Develop anticoagulant reversal posters and NOF pre-op checklist. • Reaudit
To explore the Occupational Therapy role in the assessment, prevention and management for delirium patients	Key Successes • MDT completing 4AT to identify patients with delirium Areas for improvement • To be compliant with NICE guidelines • OT's completing cognitive screens with delirious patients and providing them with diagnosis of significant cognitive impairment • Poor therapy management of delirium patients Key Actions • To raise delirium awareness across the Trust • Roll out OT and MDT education
Total ankle replacement update	Key Actions • Enable TAR database to be accessible on shared drive • Standardise TAR pathway • Review walker boot
Vetting referrals from Gastro clinic waiting list	Key Successes • Senior clinical triage vetting of outpatient referrals – improved the outcomes of the waiting list such as unnecessary medical gastro clinic appointments Areas for improvement • GP referrals for probable coeliac disease with positive coeliac marker blood test results to the Trust open access OGD pathway for duodenal biopsies Key Actions • Primary care leads informed of results to ensure correct use of the open access pathway for duodenal biopsies • Review gastro team plan to sustain a process of real-time vetting to ensure patients on the correct pathway

Participation in Clinical Research

In 2022-2023, 484 patients receiving NHS services provided by the Trust participated in research; 481 of whom were recruited into National Institute for Health Research (NIHR) portfolio studies. The UK clinical research delivery system is facing unprecedented challenges to support the delivery of research, following the COVID-19 pandemic. In response to the ongoing challenges in research delivery, the Department of Health and Social Care (DHSC) has introduced the Research Reset programme with the aim of making portfolio delivery achievable within planned timelines (time and target) and sustainable within the resource and capability we currently have in the NHS. It aims to free up capacity across the research system, by working with funders and sponsors to support the review of studies that have already completed, or that are unlikely to be able to deliver their endpoints in the current environment.

Throughout 2022/23 research delivery within the Trust has been supported by a small administrative team (3 WTE), 8 Research Nurses (6.2 WTE) and a Research Midwife (0.6 WTE). Much of the

research involves collaboration with the Northwest Coast Clinical Research Network and academic and industry institutions. The Research Department works closely with local principal investigators, pharmacy, pathology and radiology to ensure that the Trust has the capacity and capability to set up and effectively run its studies. During this time there were 72 studies open to recruitment across all the divisions and we were supported by 68 Principal Investigators (PI) with studies open to recruitment or in follow up. We have had three junior Doctors successfully complete the Associate Principal Investigator Scheme which increases our future PI capacity. Two applications aligned with regional and national programmes for research career pathways have been successful, which will bring reputational advantage and foster new Wirral-led research. An NIHR NWC ARC [50]Internship to apply for an NIHR Advanced Research Fellowship and an NIHR Senior Research Leader.

Some of our study successes during this period have been our highest recruiting study STOP RSV (Paediatrics) recruiting 132 (aim 70). We have continuously been recognised in the top 5 recruiting sites nationally for the Critical Care study GenOMICC and we were also the highest recruiting site nationally in November for ROSSINI a surgical study. We successfully worked in collaboration with Primary Care (Marine Lake Medical Centre) for the HARMONIE RSV vaccine study, by providing Pharmacy, Clinic space and Research Nurse support whilst also acting as a Participation Identification Centre, this collaboration has just been nominated for Research Collaboration of the Year in the North West Research and Innovation Awards 2023.

The new Wirral Research Collaborative (WRC) has been created for Primary-Secondary-Tertiary collaboration going forward. The inaugural meeting was held in March 2023 and a strategic funding bid was submitted in February and we were one of a relatively small number of bids across the Network to be successful in being awarded funding. Further meetings are taking place with key partners across the Network to work through the aims, objectives and capacity of what the WRC will deliver in the next 12 months.

In 2022/23, there were changes within the Research Department. In September 2022, the new role of Clinical Research Lead was appointed and the Research Divisional Leads were disbanded. In October a new Interim Research and Innovation Manager was appointed. The Research and Innovation Committee, chaired by the Chair of the Board of Directors, was formed and first met in October 2022 and continues to meet quarterly to drive the delivery of the Research and Innovation Strategy. The Research and Innovation Strategy has been devised in year and has seen delivery of year 1 plans.

At the end of 2022/23 the department was given the approval to relocate the Research and Innovation Department to the Vaccine Hub at our Clatterbridge site which will provide the department with a greater infrastructure and dedicated facilities to develop research further within the Trust and with our partners.

Commissioning for Quality and Innovation (CQUIN)

		Target		
No	**Title**	**Minimum**	**Maximum**	**Q4 %**
CCG1	Staff Flu Vaccinations (*)	**70%**	**90%**	**62.5%**
CCG2	Appropriate antibiotic prescribing for UTI in adults aged 16+ (*)	**40%**	**60%**	**54.00%**
CCG3	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions (*)	**20%**	**60%**	**100.00%**

[50] NIHR APPLIED RESEARCH COLLABORATION NW COAST

CCG4	Compliance with timed diagnostic pathways for cancer services (*)	**55%**	**65%**	**0.00%**
CCG5	Treatment of community acquired pneumonia in line with BTS care bundle	**45%**	**70%**	**9.84%**
CCG6	Anaemia screening and treatment for all patients undergoing major elective surgery	**45%**	**60%**	**100.00%**
CCG7	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service (*)	**0.50%**	**1.50%**	**26.82%**
CCG8	Supporting patients to drink, eat and mobilise after surgery	**60%**	**70%**	**97.62%**
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	**20%**	**35%**	**11.67%**

CQUINs we reinstated in 2022/23 following the pause during the COVID Pandemic. There were nine CQUINs that were agreed applicable to the Trust;

- CCG1 – Staff Flu Vaccinations
- CCG2 – Appropriate antibiotic prescribing for UTI in adults aged 16+
- CCG3 – Recording of NEWS2 score, escalation time and response time for unplanned critical care admission
- CCG4 – Compliance with timed diagnostic pathways for cancer services
- CCG5 – Treatment of Community Acquired Pneumonia in line with BTS care bundle
- CCG6 – Anaemia screening and treatment for all patients undergoing major elective surgery
- CCG7 – Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
- CCG8 – Supporting patients to drink, eat and mobilise after surgery
- CCG9 – Cirrhosis and fibrosis tests for alcohol dependent patients

During the year there has been oversight of the programme and clinical leads for each CQUIN have been able to discuss challenges, monitor actions and seek resolutions. The Trust has exceeded the maximum incentive targets for 4 CQUINs by the end of 2022/23. The Trust has demonstrated improvement throughout the year and exceeded the minimum incentive targets for a further CQUIN by the end of 2022/23.

The remaining CQUINs include CCG4, where the Trust made a decision that the resource required to report against stages of the Faster Diagnostic Standards was greater than the value added. This is in the context of the Trust consistently achieving this standard during 21/22 (11 out of 12 months) and mostly through 22/23.

The final CQUINs that was not achieved by the end of 2022/23 relates to referral of alcohol dependent patients for Cirrhosis and fibrosis tests and treatment of community acquired Pneumonia in line with BTS care bundle. During the year the Trust has made progress with both of these CQUINs but the outcomes have not been observed in year. Referral pathways for Cirrhosis and Fibrosis Tests have been reviewed during the year and this rate will be monitored into 23/24 to ensure service for our patients. Similarly the patient Electronic Record System has seen amendments to improve reporting of compliance with BTS care bundle and this will also be monitored through 2023/24 to observe the improvements required.

During the year the Trust has strengthened oversight of CQUINs with regular meetings between the Clinical Effectiveness Team and CQUIN leads and formal reporting through the Clinical Outcomes Group.

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. There are no conditions imposed on the registration for Wirral University Teaching Hospital NHS Foundation Trust.

During the year a new location has been added. The Seacombe Birth Centre has been registered with CQC in August 2022 and will support mothers to choose a birth outside of the acute hospital, where appropriate for the level of assessed risk.

The Trust produced a CQC action plan and so the requirement to improve is held on that action plan for discussion with the CQC.

The Care Quality Commission has not taken enforcement action against Wirral University Teaching Hospital NHS Foundation Trust during 2022/23.

Wirral University Teaching Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission (CQC) undertook an unannounced inspection of Urgent and Emergency Care and Medical Services in October 2021, this was a responsive inspection. The inspection was undertaken during the ongoing Covid 19 pandemic and at a time of significant pressures on health services. The inspection report was published on Friday 14 January 2022. The inspection did not result in a change in the overall rating of Requires Improvement for the Trust or the location of Arrowe Park Hospital; the ratings remain as determined post the trust wide inspection in late 2019. This is because the inspection only covered two of the services within the hospital and did not include a trust wide well led review.

Following the inspection in October, the rating for the two services involved were reviewed and updated, the table below shows the rating for each services following the 2019 and 2021 inspections.

	Medical Services		**Urgent and Emergency Care Services**	
	2019 Inspection	2021 Inspection	2019 Inspection	2021 Inspection
Overall Rating	Requires Improvement	Good	Requires Improvement	Requires Improvement
Domains				
Safe	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Effective	Requires Improvement	Good	Good	Good
Responsive	Requires Improvement	Good	Requires Improvement	Requires Improvement
Caring	Good	Good	Good	Good
Well Led	Requires Improvement	Good	Requires Improvement	Good

The current CQC action plan is made up of 15 actions following the 2021 targeted CQC inspections and a further 31 legacy actions from the previous 2018 and 2019 CQC inspections. The Patient Safety and Quality Board maintains oversight of delivery of the action plan to ensure actions are progressed and discussed efficiently.

In relation to the new CQC quality statements that were published in July 2022 the Trust is undertaking self-assessment work, which involves development of a CQC Dashboard consisting of all 34 statements with internally defined measures of assurance being assigned to each statement. This will consist of the new evidence categories, which are:

- Outcomes (Performance Data, Audits, Incidents etc,)
- Process (in place - Policy / Procedure)
- Process (compliance)
- Feedback from Staff and Leaders (Tendable, Staff Survey, Trainee Surveys, Freedom to Speak-Up)
- People's Experience of Health and Care Services (Patient Experience Reports, Complaints, Workshops)
- Feedback from Partners (360 commissioners / peers / regulators etc.)
- Observation (CQC Mock Inspections)

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.

The Trust has reviewed the arrangements for the FTSU service and aligned roles for FTSU and Just and Learning Culture, this has led to appointment of a new Lead FTSU Guardian and Just Culture Lead in 2023. They are supported by two existing guardians in the trust along with a network of 20 FTSU Champions, whose role is to work within their service areas, promoting and encouraging staff to speak up and signposting to FTSU Guardians where appropriate.

Where a member of staff does not feel able to speak up through the normal management channels, they are encouraged to contact a 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 continues to see low numbers of anonymous concerns raised with only 8 received in 2022/23, which, combined with positive levels of people speaking up, can be a good indication that staff continue to feel 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 remain unresolved.

The Trust has seen a reduction in the number of people speaking up this year with 91 people speaking up in 2022/23 as opposed to 128 people in 2021/22. This reduction is seen as a positive and data now falls more in line with regional and national averages.

Our 2022/23 data shows that people accessing the speak up service are across all Divisions and a range of occupational groups.

Attitudes and behaviors continue to be the most reported theme with 9 concerns linked with patient safety, compared to 17 last year. Numbers of staff speaking up regarding patient safety have therefore reduced significantly and are lower than national and regional comparators. Whilst this can be seen as a positive position, with staff reporting positive links with senior management teams and effective incident reporting processes, further promotion of the FTSU service and enhanced engagement with clinical staff will be undertaken for 2023/24.

Additional sources of advice and support continue to be available for concerned staff. These include tutors (for students and trainees), Practice Education Facilitators, the Human Resources department, Trade Unions and professional bodies, the Guardian of Safe Working for Junior Doctors, and Staff Support Team. The Trust has also appointed a Pastoral Lead for staff, along with pastoral leads for internationally recruited nurses, clinical support workers and for our staff undertaking widening participation programs e.g., apprenticeships and volunteers. Whilst these services might not necessarily be able to investigate the concerns themselves, they offer advice, guidance and support and signposting to specialist services as appropriate, including services of the FTSU Guardian team.

The Trust continues to operate 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 and workforce wellbeing team, Employee Assistance Program and a range of national and local community organisations depending on the individuals' circumstances.

The Trust continues to proactively identify and support staff who share protected characteristics or may be identified as less able / willing to speak up, with excellent links in place with the Trust's Equality, Diversity and Inclusion Lead and a number of WUTH staff network members including LGBTQ+, Multicultural, staff with disabilities and long-term conditions, the menopause network, armed forces network have developed to become FTSU Champions.

Regular reports are produced and submitted to a variety of Trust Management Committees to ensure appropriate monitoring and governance. Potential trends and themes are monitored to ensure 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 this 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. No WUTH staff have reported detriment.

The Trust continues to link with regional and national FTSU Guardians and NGO[51] representatives 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 England; Health Education England (for education and training issues) and NHS Protect (where there are suspicions of fraud and corruption.

Hospital Episode Statistics

WUTH submitted records during 2022-23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

[51] National Guardian's Office

Commissioning Date Set Type	Period	NHS Number	Registered GP Practice
Admitted Patient Care	Apr 22 to Mar 23	99.9%	99.8%
Outpatient Care	Apr 22 to Mar 23	100%	99.9%
Emergency Care	Apr 22 to Mar 23	96.1%	99.2%

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 awaiting Phase 1 of the required annual audit of the Data Security and Protection Toolkit (DSPT) which will be undertaken by Mersey Internal Audit Agency in March 2023, feedback is due in June 2023. Last year 'Substantial Assurance' was achieved in 12 out of the 13 areas with 'Moderate Assurance' in 1 area. This resulted in achieving 'Moderate Assurance' overall in the 2021/22 MIAA external audit.

Last year the submission date for the DSPT was changed from March to June and this remains the same for this year. Therefore, the DSPT will be submitted at the end of June 2023. The Trust attained 'Approaching Standards' in the 2021/22 submission in June 2022.

The main focus for the year has been to continue to work collaboratively to support the One Patient Record project as we move towards a fully digital record. We continue to support the latest technologies by risk assessing and enabling the personal data of patients and staff to be processed in a legal, efficient, and secure way. Our processes are continuously reviewed in line with current good practice, guidance, and legislation to ensure the most up to date advice is provided to reduce the information risk across the organisation.

Four data breaches were reported to the Information Commissioner's Office (ICO) by the Trust (see table below). One of the breaches did not meet the requirement to report however for complete transparency the Trust chose to report. In addition, a third party under contract to us, though a Data Controller in this instance, had a data breach involving staff data and informed the ICO who confirmed it did not meet the required threshold for reporting.

ICO Number	Date	Incident Details
IC-171328-D8G0	May 2022	Confidentiality breach by NHSP worker Status: No further action.
IC-174069-T0Q9	June 2022	A staff member looked up the care home address of an estranged relative and passed it on to her son. Status: No further action.

IC-180898-Z4B8	July 2022	A copy of a deceased patient's case notes were sent to the incorrect applicant. The Data Protection Act does not apply to deceased individuals however for full transparency this was reported. Status: No further action.
IC-215176-P5F5	February 2023	Patient letters can be sent to a previous temporary address due to an overwrite of Millennium that can occur when an end date of a temporary address is updated on EMIS but it is then not reflected on the Spine. This appears to be a national issue. Status: No decision received yet.

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 2022/23 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 Cardiology and Gastroenterology coding performed in September 2022 with overall accuracy of our coded data reported as:

- 94.17 % for primary diagnosis
- 93.92 % for secondary diagnosis
- 91.18 % for primary procedure
- 90.32 % for secondary procedures

A second audit was performed on Gynaecology and Trauma & Orthopaedics coding in January of 2023. The overall accuracy of our coded data is reported as:

- 93.33 % for primary diagnosis
- 94.60 % for secondary diagnosis
- 93.85 % for primary procedure
- 90.28 % for secondary procedures

These external audits were supplemented with additional internal audits throughout the year focusing mainly on the accuracy of individual coders. We have two Approved Clinical Coding Auditors in post. The Trust was not subject to the Payment by Results Clinical Coding Audit during 2022/2023.

The Trust will be taking the following actions in 2023/24 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 receive relevant feedback at individual and team level as appropriate.

To ensure standards and development within the clinical coding team, an in-house course followed by online examination and accreditation has been implemented. This has supported two further members of staff achieving accreditation during 2022/23 and further staff planned for accreditation

in 2023/24. This is a key priority to ensure sustainable and resilient service with trained clinical coders being a difficult resource to recruit.

Learning from deaths

During 2022/23, 1,896 of Wirral University Teaching University patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 414 in Quarter 1 (April-June 2022)
- 446 in Quarter 2 (July-September 2022)
- 533 in Quarter 3 (October-December 2022)
- 503 in Quarter 4 (January-March 2023)

The Medical Examiners (ME) continue to maintain scrutiny of all mortalities with the Trust and escalates cases where potential concerns are identified, which are then reviewed by the Mortality Review Group (MRG) held fortnightly.

The MRG discusses findings from these escalated mortality reviews, where key clinicians scrutinise the patient journey, including lessons learnt and whether their deaths could have been prevented. Additionally, Structured Judgement Reviews (SJR) are performed, and mortality reviews for all deaths where the patient has a learning disability or autism. Furthermore, mortality reviews are performed on a random sample of patients, and any concerns are highlighted at the MRG.

During 2022/23 a total of 191 mortality reviews were completed. This consists of 74 PMRs, 18 SJRs including 11 LeDeR reviews, 88 QA PMRs.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 56 in the first quarter
- 51 in the second quarter
- 50 in the third quarter
- 34 in the fourth quarter

17 cases, representing 0.89% of the patient's deaths during 2022-23, are judged to be more likely than not due to potential issue with developing nosocomial Covid-19. Each of these mortalities were also scrutinised by an Infection Control review, to learn from findings and prevent future infections.

In relation to each quarter, this consisted of:

- 2.65% of deaths for the first Quarter (n=11)
- 1.3% of deaths for the second Quarter (n=6)
- 0.00% of deaths for the third Quarter (n=0)
- 0.00% of deaths for the fourth Quarter (n=0)

This data also includes outcomes from the various mortality reviews performed, including those using the structured judgement methodology together with the serious incident framework; learning disability reviews based on the LeDeR (Learning from lives and deaths – People with a learning disability and autistic people).

Summary of learning, actions The Trust has undertaken and the impact of the relevant actions:

Learning	Actions Implemented
Medication delays and errors	All cases are fed back via the Medications safety Pharmacist (who is a member of MRG) to relevant areas and MSOP committee that has oversight of medication safety across the Trust.
Delays in discharge home (Patients without criteria to reside)	Work ongoing at system level to address delays in discharge
Multiple ward moves	Ward moves audit commenced to learn lessons and look at process around bed allocation
Poor documentation	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads.
Poor documentation around MCA and DNACPR decisions	All these cases are feedback to individual teams and the Trust CPR committee. MCA training and has been refreshed across all areas recently and audits of DNACPR forms strengthened to ensure better compliance.
Communication with families	In cases where this has happened, the feedback was taken to clinical teams to reflect and improve.

Seven-day service

The Seven Day Hospital Services Programme was stepped down during the pandemic and reinstated in Feb 22. The standards have been embraced within the Trust and are reviewed via the Trust Clinical Outcomes Group.

Standard	Assurance
Patient Experience	Will be actively recording a difference between weekend or weekday in a quality questionnaire going forward
Time to first consultant review	Audit results provided in table below
MDT review	There is a therapy unplanned care team who operate 7 days a week 8-20:00 Monday to Friday and 8-18:00 Saturday and Sunday. This means that all ED patients are reviewed by an OT or Physio as part of the MDT within 14 hours. The Trust has Mon-Friday cover for SLT[52] and dietetics for ED as well, however this is only 9-16:00 and on an ad hoc basis.
Shift handovers	Twice daily shift handovers are completed for all hospital areas. The handovers are standardised across the 7 days of the week and times are consistent but do occur at different times of the day for each service need. Most handovers do have consultant involvement; however some handovers are represented by senior registrars as the senior decision maker.

[52] Speech Language Therapy

Diagnostics	There is an established process for critical scans where the clinician contacts radiologist to agree that the scan is clinically critical. Once accepted the patient is given the next slot on the scanner. Earmarked scanners are used to ensure that urgent patients are scanned within 12 hours and non-urgent within 24 hours. NICE guidance is being followed for suspected metastatic spinal cord compression and scan within 24 hours.
Intervention / key services	24 hour access to onsite thrombolysis is available 24 hour access to thrombectomy is provided at The Walton Centre following WUTH triage and consultant review/referral
Mental health	Mental Health Liaison Service is present within the Trust 24 hours 7 days per week. The Mental Health Liaison Service provided through Cheshire and Wirral Partnership NHS FT work closely with the Trust through the Mental Health Transformational Group to ensure these standards are achieved.
Ongoing review	Please see evidence below for standard 8
Transfer to community, primary and social care	Every Specialty has a 24 hour consultant rota which Medical Staffing record. Any issues with the rota are managed divisionally with the Senior Medical Workforce.
Quality Improvement	Please see data for full year 2022/23 in graph below

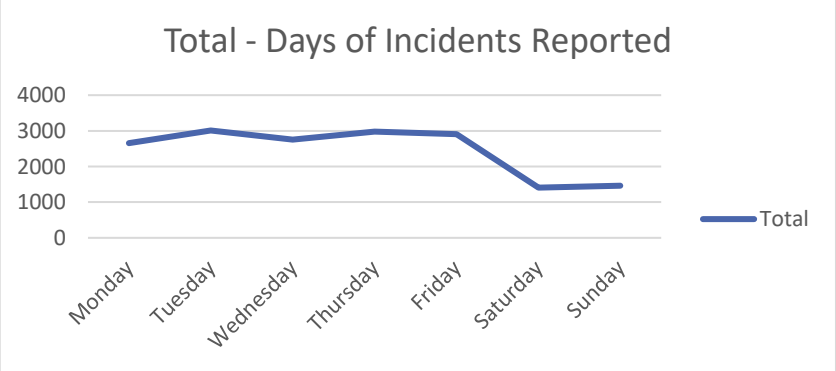
The table below demonstrates the compliance throughout 2022/2023:

Standard 2 Time to first consultant review (14 hours)	Q1	Q2	Q3	Q4
Weekday	63%	69%	69%	65%
Weekend	65%	53%	60%	59%

All patients with high dependency reviewed twice daily by a consultant:

Standard 8	**Q1**	**Q2**	**Q3**	**Q4**
	73%	68%	66%	66%

Incident reporting rates by day of the week, demonstrates the reduced incident reporting over the weekend. This is initially presumed to align to the reduced elective activity over the weekend, however further analysis will take place via the Clinical Outcomes Group.



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 October 2022)	01/11/2021 -31/10/2022	1.06 Banding 'As Expected'	1.00	0.62	1.24	1.07 Banding 'As Expected'
	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 (NHS Digital). Wirral University Teaching Hospital has taken the following actions to improve this indicator, and so the quality of its services: • Continued to develop the Mortality Review processes within the Trust as described within the Learning from Deaths quarterly reports. • Supported deep dives into any areas of concern through the Trust Clinical Outcomes Group.						

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
3 - Helping people to recover from							
	Patient Reported Outcome	April 2020 – March 2021	0.440	0.463	-0.134	0.841	0.427

episodes of ill health or recover from injury	Measures (PROMS) - Primary Hip Replacement Surgery						
	Patient Reported Outcome Measures - Primary Knee Replacement Surgery	April 2020 – March 2021	0.234	0.303	-0.165	0.923	0.286
	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 its services by: • Review of PROMS within Orthopaedic clinical governance meetings • Review of Patient Experience feedback within clinical governance meetings						
	The percentage of patients readmitted to any hospital in England within 30 days of being discharged from hospital after an emergency admission during the reporting period, aged: • 0 to 15 • 16 or over	2021 - 2022 <16 years	18.4	12.5	9.9	17.0	19.2
		2021- 2022 16+	13.4	14.7	10.8	19.1	14.7
		2021-22 16-74	12.2	13.4	9.4	16.8	13.2
		2021-22 75+	16.6	18	13.1	35.2	18.7
	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 its services by: • Working to improve discharge information as a patient experience priority. • Reviewing and improving the effectiveness of discharge planning. • The Trust monitors readmission information and takes action as required.						

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	2020-21	75.1	74.5	67.3	85.4	68.4
	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 has taken the following actions to improve this percentage score, and so the quality of its services by: • Corporate team is working closely with the Divisions to formulate actions plans in response to patient carer feedback.						
	Staff recommend the Trust as a provider of care to their family and friends	2022	62.1%	61.9%	39.2%	86.4%	67.8%
	Wirral University Teaching Hospital considers that this data is correct for the following reasons: • The survey is owned by NHS England and the Staff Survey Coordination Centre is based at Picker Institute Europe. Wirral University Teach Hospital has taken the following actions to improve the percentage score and so the quality of its services by: • Leaders in Touch • Quarterly Pulse Survey • Establishing staff networks in order to ensure staff have opportunity to not only gain access to the results, but to also contribute their ideas and shape plan's.						

Domain	Indicator	Reporting period	WUTH	National Performance			Previous
				Average	Lowest	Highest	
5 - Treating and caring for							
	Rate of C.difficile infection (hospital onset)	2021/22	24.7	16.5	0	53.6	19.2

<table>
<tr><td>people in a safe environment and protecting them from avoidable harm</td><td>
Wirral University Teaching Hospital considers that this data is correct for the following reasons:
There is a robust sign off process each month to validate all data that is submitted.
Wirral University Teaching Hospital has taken the following actions to reduce infection and so the quality of its services by:
A comprehensive Trust wide Improvement Plan has been implemented and progress is monitored via the Infection Prevention and Control Group.
<table>
<tr><td>Patient Safety Incidents</td><td rowspan="2">Oct 2019 - Mar 2020</td><td>No: 6096
Rate: 47.5</td><td>6502</td><td>1271</td><td>22340</td><td>No: 6442
Rate: 49.9</td></tr>
<tr><td>Percentage of patient safety incidents that resulted in severe harm or death.</td><td>9</td><td>20</td><td>0</td><td>93</td><td>8</td></tr>
</table>
Wirral University Teaching Hospital considers that this data is correct for the following reasons:
The Trust actively promotes a positive incident reporting culture.
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:
Undertaking comprehensive investigations of incidents resulting in moderate or severe harm, utilising varying forums for learning such as ward huddles and Trust Communication(s).
Providing staff training in incident reporting and risk management.
Monitoring through the serious incident panel.
Ensuring the transition to Learning from Patient Safety Events, due to go live September 2023, is within expected time frames and have met the March deadline testing the system.
</td></tr>
</table>

Several the data sources for the Quality Accounts are under review at the moment, following the merger of NHS Digital with NHS England. For example, the NHS Outcomes Framework, which provides some of the indicators, is being redesigned. In these instances, trusts are permitted to use the latest available data.

3 Part 3

Overview of the Quality of Care and Performance

We describe within the following section, additional improvement activities that we have undertaken within year. Our examples focus on our staff; our Emergency Department (ED) and Patient Safety.

3.1.1 Staff survey

The NHS Staff Survey, undertaken by independent external organisation, Picker Europe, took place between September and November 2022. The Trust applied a mixed mode of paper based and electronic (via email) surveys in order to maximise access and completion of survey.

This year was the largest return rate in the last 6 years with a 2% increase on 2021 survey, with 3,135 responses, totalling 48% (47.86% actual) response rate. Trust results were aligned to the Acute and Community & Acute sector for which 126 Trusts results were compared. The survey results were categorised against the national NHS People Promise.

The People Promise is now a thematic benchmark for which NHS Staff Survey is measured across the seven elements. It also measures two elements of the survey separately as it has in previous years, Engagement & Morale. NOTE: This is also congruent with the Trusts People Strategy which acknowledges the requirements of the national People Promise.

Overview of People Promise theme results and comparisons to the national average:

People Promise Elements	**Trust 2022 scores**	National **Average**
We are compassionate and inclusive	7.2	7.2
We are recognised and rewarded	5.7	5.7
We each have a voice that counts	6.6	6.6
We are safe and healthy	5.9	5.9
We are always learning	5.3	5.4
We work flexibly	5.8	6.0
We are a team	6.5	6.6

The Trust scores 'on average' or slightly below average, but not statistically significantly so, when benchmarked with comparators across all the people promise domains. Below, are the scores for the two themes outside of the NHS People Promise that remain a key benchmark for the National NHS Survey, 'Engagement' and 'Morale'. NOTE: there has been no change in these scores since 2021 survey.

Theme	**Trust 2022 score**	**National Average**
Engagement	6.7	6.8
Morale	5.7	5.7

The 2022 staff survey results will be used as one of a number of engagement diagnostics that enable '*staff voice'* to be heard and acted upon. The results of this year's survey will be used to shape the priorities for 2023/24 Trust wide plans including People Strategy delivery plan. Further to this, survey results will also inform 2023/24 divisional delivery plans. A programme of cascade will be implemented throughout March and April, drawing upon technological solutions and established staff networks in order to ensure staff have opportunity to not only gain access to the results, but to also contribute their ideas and shape plans.

Occupational Health & Workforce Wellbeing

We are committed to supporting the health and wellbeing of our staff and as such have developed the looking after ourselves and each other principle within our People Strategy. We have introduced a number of measures to offer enhanced support, boost morale, support mental and physical wellbeing and to help build resilience.

Improvement achieved this year includes:

- Collaborative and holistic wellbeing approach continues to be taken, with wellbeing and professional nurse advocates to ensure provisions are in line with the needs of our workforce.
- Holistic health checks have been offered to staff, with health kiosks situated on both of our Trust sites throughout March.
- Our staff networks have continued to flourish, and staff are encouraged and welcomed to join. Our current networks are the Sunflower network (for people with disabilities or long-term health conditions), Rainbow Alliance – for our LGBTQ+ staff and allies, Multicultural Staff Network (formerly our Black, Asian and Ethnic Minority network), Menopause Staff Network and Armed Forces Staff Network. All our networks are supported by an Executive Partner.
- "Wellbeing surgeries" have continued, with a focus on issues such as physical health, financial well-being and support for staff with disabilities and long-term health conditions,
- Staff wellbeing areas have been refurbished and opened.
- Wellbeing continues to be integrated into wider leadership & management offerings e.g., leadership masterclasses within new leadership qualities framework and will form a key part of our new appraisal process which is currently underway.
- A programme of seasonal vaccinations has been delivered, with all staff being offered a flu vaccination alongside a covid-19 booster.
- Morale boosters and staff engagement events have taken place throughout the year such as the annual staff awards ceremony, Christmas door competitions, Trust charity fundraising events and social media campaigns celebrating a wide range of special events such as International Women's Day and Overseas NHS Workers Day.

Areas of focus for the forthcoming year:

The Trust People Strategy has a significant focus on Wellbeing and sets out a vision of developing a wellbeing culture across the Trust. Key priorities include:

- Deliver first class, innovative Occupational Health and Wellbeing Services in line with the national Grow OH strategy.
- Equipping our line managers and leaders with the knowledge, skills and tools to develop a wellbeing culture within their teams.
- Further development of our just and learning culture.
- Fully embracing flexible working across all roles.
- Creating the conditions for civility and respect amongst our people.
- Embed quality supervision and appraisal conversations, which includes regular and on-going individual well-being check ins.

3.1.2 Quality and Safety within ED

This year 129,096 people attended the Trust for urgent and emergency care - a 2% increase on the previous year.
The national standard for measuring performance is that 95% of patients should be seen within 4 hours and either admitted or discharged. It remains a significant challenge for the Trust to meet this standard.

Several important factors are required to achieve the standard. The most important being good 'flow' through the hospital, i.e. at least as many patients must be discharged as require a hospital bed. The ability to achieve good flow has proved difficult this year and has led to increasing pressure on the emergency department.

The Trust is working with system partners to address the challenges of 'flow' and to ensure that patients receive their care in a place that best meets their needs. Recently, several initiatives have been implemented to improve patient flow out of hospital and these initiatives will continue through to 2023/24.

Collaborative work with our partners will be critical to ensure that we continue to work to restore and improve our urgent care pathways.

Construction of the new urgent and emergency care department is ongoing. It is anticipated that the Trust will open a number of new areas in the department later in 2023/24, allowing for a phased move into the new building.

The challenges highlighted above have meant that patients spend an increased length of time in the ED which has raised further challenges for the department, for example completion of risk assessments which would historically have been completed once they were admitted onto an in-patient ward as well as the prescribing of critical and routine medications. The introduction of patient-focused rounding has increased patient safety and improved patient experience whist in the waiting room and on the ED corridors.

The division has developed an improvement plan to address these challenges in order to maintain patient safety. An increased focus has been applied to reducing patient harms associated with an increased length of stay such as skin integrity, falls and early recognition/prevention of clinical deterioration. Improved governance processes has enabled a more coordinated approach, ensuring that learning opportunities are shared, thus reinforcing ownership and accountability.

Poor egress from the ED has led to overcrowding which has increased the need to provide corridor care for patients brought in by ambulance which has its challenges such as lack of privacy and dignity, lack of toileting facilities and no piped oxygen. However, the introduction of the Ambulance Arrivals Zone (AAZ) has enabled this patient group to be accommodated in a more appropriate area where their needs can be met fully. An increase in nursing establishment has enabled the expansion of the current ED to incorporate AAZ.

Maintaining effective communication with patients during this period of increased attendance and overcrowding has also been an area of challenge. Various initiatives have been introduced to address this area such as screens showing the number of patients in the department, time to triage and time to wait to see a clinician and an automated announcement system which will be introduced later this year.

Maintaining patient safety and ensuring a positive patient experience relies on staff having the correct tools to deliver this. There has been increased focus on staff wellbeing and resilience during this time of increased pressure.

3.1.3 Patient Safety:

The Trust continues to prioritise patient safety and continually seek quality improvement. During the year the Trust has approved the Quality and Safety Enabling Strategy and this has now been published.

The Quality and Safety Strategy priorities have been highlighted in line with the Trust quality priorities for the forthcoming year and delivery will be monitored through the trust Patient Safety and Quality Board and the Quality Committee to the Trust Board.

The publication of the Patient Safety Incident Response Framework (PSIRF) has been a key step in delivery of the NHS Patient Safety Strategy and the Trust has responded with a PSIRF Implementation plan and a PSIRF Implementation Group has initiated a series of planned workshops to co-produce the Trust approach, delivery plan and policy for PSIRF. This work will continue into 2023/24 and evolve across the Trust and Place to ensure patient safety remains a key priority.

3.1.4 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.

We take our responsibilities in relation to investigating never events very seriously. We have reported two Never Events during 2022/2023 under the following category:

- Transfusion or transplantation of ABO-incompatible blood
- Wrong site surgery (Ophthalmology)

The Never Events underwent a full investigation by the Trust and learning has been disseminated and discussed through the appropriate routes with the ICB. Learning from Never Events and other Serious Incident investigations is discussed regularly to support a learning culture.

3.1.5 National Safety Standards for Invasive Procedures (NatSSIPs) 2

Safety around invasive procedures has been a focus within the Trust and significant improvement has been seen. The launch of NatSSIPs 2 has provided an opportunity to review our progress to date and consider further actions to strengthen safety for invasive procedures. The Trust has progressed guidance in relation to local safety standards and these standards have been approved for use. Key progress moving forwards will increase oversight of the consistent application of the defined safety standards.

3.1.6 Rota gaps (doctors and dentists in training) and the plan for improvement to reduce these gaps

Gaps within placement rotations for doctors in training, alongside vacancies in other staff groups and intensifying workload are challenging not only for WUTH but across the NHS. Rota gaps are influenced by a range of factors involving several different external stakeholder organisations (e.g. specialty training and foundation training programmes, lead employer NHS trust). Internally within WUTH, several departments including medical staffing, medical education & Guardian of Safe Working are involved in monitoring and addressing the impact on both educational and service delivery resulting from rota gaps. Data from the GMC training survey, local surveys and feedback via the Junior Doctors Forum helps triangulate the impact of rota gaps. The recruitment of locally employed trust grade doctors and other experienced clinicians assists reduction of impact resulting from gaps within doctors in training rotations. Further collaboration between relevant stakeholder groups to identify further mechanisms for improvement is on-going.

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 2022/23 – 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	80%	59.09%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (Arrowe Park site)	95%	64.07%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (WUTH ED only)	95%	51.33%

All cancers: 62-day wait for first treatment from: Urgent GP referral for suspected cancer	85%	74.74%
NHS Cancer Screening Service referral	90%	86.03%
C. difficile: variance from plan	72	143
Maximum 6-week wait for diagnostic procedures	99%	92.11%
Venous thromboembolism (VTE) risk assessment	95%	98.1%

4 Appendices:

Appendix One: List of relevant Health Services provided by the Trust

ACUTE SPECIALTIES DIVISION (2)

Emergency Department	Acute Medicine
Frailty	

MEDICAL SPECIALTIES DIVISION (14)

Department of Medicine for the Elderly	Rheumatology
Cardiology	Haematology
Gastroenterology	Endoscopy
Diabetes and endocrinology	Dermatology
Nephrology	Stroke
Cardio-respiratory investigations Lab	Rehabilitation
Respiratory	Palliative Care/End of Life

DIAGNOSTICS AND CLINICAL SUPPORT DIVISION (10)

Pathology	Cancer Pathway Management
Bed Management	Radiology
Integrated Discharge Team	Therapies
Booking and Outpatients	Pharmacy
Limb Centre (& MSK)	Critical Care

SURGICAL DIVISION (19)

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	Sterile Services
Vascular	

WOMEN'S AND CHILDREN'S DIVISION (12)

Paediatrics (Children's Ward / Paediatric Assessment Unit)	Community Paediatrics
Obstetrics and Maternity Services	Community Midwifery
Neonatal Unit	Gynaecology
Termination of Pregnancy	Breast Service
Antenatal Screening	Fertility Service
New-born Hearing Screening	Paediatric Audiology

CORPORATE SERVICES (28)

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

Chaplaincy	Cancer Pathway
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	Research & Development
Validation Team	Outpatient Nursing

Appendix Two: Healthwatch Wirral Commentary for Wirral University Teaching Hospital NHS Foundation Trust 2022/23

Healthwatch would like to thank Wirral University Teaching Hospital NHS Foundation Trust (WUTH) for the opportunity to provide a Commentary for the Trust's Annual Quality Account 2022/23
The Quality Account is a substantial document with considerable data, facts and figures. Therefore, we have focused our Commentary on the areas below which are related to the Priorities which are either not being achieved or partially achieved. We will also provide Commentary in relation to Freedom to Speak Up and Learning from Deaths.

1. **To improve Patient Safety, we will reduce hospital acquired infection rates with a targeted reduction in those that are part of the quality requirements for NHS Trusts and NHS foundation trusts as determined by NHSE/I.** Not achieved

Improvements have obviously been achieved within this Priority and it is good to see a downward trend in positive infections. During Covid-19 Pandemic the promotion of handwashing protocols was substantial – the importance of this message appears to have reduced a great deal. Healthwatch Wirral would encourage the Trust, and other care services, to raise the bar again with the IPC messages relating to Handwashing for patients, staff and visitors.

2. **Management of the Deteriorating patient (as part of Harm free care): To continue a structured Quality Improvement programme to improve the early recognition, escalation, and response to the deteriorating patients with successful impact measured through data.** Partially achieved**.**

Although difficult to read, for non-clinical people, Healthwatch acknowledge that vacancies and absences appear to be a contributor to the partial achievement of this Priority. However, going forward it is important to demonstrate, in simpler language, what this Priority will achieve over and above better data management and collection.

3. **To increase access and availability to outpatient appointments.** Partially achieved.

It would be helpful to understand more about the Patient Initiated Follow Up process to enable Healthwatch to make a more robust comment. Some very recent feedback, received by Healthwatch from a patient would indicate, and support the Trusts declaration, that there is still some work to be done on this process.
The patient experience feedback indicates 95% – it would be clearer to know how many patients have actually fed back on this process.

Freedom to Speak Up
Healthwatch acknowledge the work in relation to the FTSU Guardians and the improvements that have been achieved. In future Quality Accounts it would be helpful to evidence that the outcomes achieved for staff, and patients where appropriate, are effective and reassuring for all parties.

Learning from Deaths
The summary of learning and actions the Trust has undertaken and the impact of the relevant actions is acknowledged by Healthwatch, especially the recognition of the need to reduce Ward moves. Healthwatch would suggest that a more robust process of capturing experiences from families could be undertaken. We would also suggest that learning from those with Sensory Impairments, or their families, would improve outcomes for everyone.

Three areas for priority action in 2023-24
The three priority areas listed below are recorded by Healthwatch and will form the basis of our Commentary for the Quality Account next year.

1. **To empower patients by increasing the opportunities to expand their role as partners in their own healthcare. Success of this priority will be measured through a variety of actions.**
   The actions taken by the Trust include patient engagement in the Promise Groups as part of the Patient Experience Strategy; also addressing health inequalities by engagement with partners to fully understand the barriers to accessing the Trusts services. It will be absolutely crucial to the success of this priority that people understand their own role in their care and communication is clear and in a format/language that they understand.

2. **To improve planning and preparation for safe transfer of care from hospital when a patient's period of inpatient admission is no longer required.**
   Success of this priority will be measured by the preparation processes which includes an Estimated Date of Discharge. It is imperative that is known not just by the clinicians and staff but by the patient and their family. Good communication prior to, during and after their discharge will contribute to ensuring transfer home is a good experience. Healthwatch can support with gathering patient experience post discharge.

3. **To build upon recent progress and further improve management of the Deteriorating Patient.**
   This priority will aim to use the National Early Warning System2 and improved coding. A very important part of the patient journey is communication. This involves speaking with patients and families and Make Every Contact Count (MECC).

Looking Forward 2023/24
The areas highlighted as key priorities for next year are noted. Healthwatch will be happy to continue to contribute to any improvement programmes to ensure the voice of those who use and deliver our care services are listened to; and that value is placed on family engagement and good communication.
The Promise Groups and the Patient Engagement Strategy work has enabled Healthwatch to support the aim of better patient experience and we hope that, if/when the current challenges subside, the plans and delivery models are truly sustainable ad inclusive.
As always, it is important to recognise the pressure that our Care Staff across WUTH, and all health and care services, face daily. Workforce is a challenge across our system and it would be impressive to see this issue tackled as a system and not as individual Trusts/Providers.
Improved systems to address and record patient safety incidents is acknowledged, by HWW, and we will aim to provide the correct balance of challenge in an effort to support all of our trusts going forward.

Foundations of Quality statement
The 'Foundations of Quality Improvement' should have what people tell us about their treatment and care at the heart of all we plan and do. We should be able to show that our actions and decisions reflect people's views. We must ensure that everyone is respected, involved, valued and confident that we are giving and receiving quality care.

Healthwatch Wirral, AgeUK Wirral, NHS England and ECIST, Wirral System.
Karen Prior
Chief Exec – Healthwatch Wirral
19 June 2023

**Trust has acknowledged the points made in relation to hand hygiene and has responded through a significant hand hygiene campaign. This included promoting effective hand hygiene through World Hand Hygiene Day on 5th May 2023 and on 14th June with the Semmelweis machine to support hand hygiene training. A handwashing training video has also been launched on ESR for all staff to complete.*

Appendix Three: Statement from Wirral Place, NHS Cheshire & Merseyside Integrated Care Board (ICB) 2022-23

On the 1st July 2022 NHS Cheshire & Merseyside Integrated Care board took responsibility for planning NHS services, including Primary Care, community pharmacy and those previously planned by clinical commissioning groups (CCGs). Wirral Place is a sub-ICB location (formerly Wirral CCG) and is one of nine localities that make up the Cheshire & Merseyside Integrated Care Board.

NHS C&M ICB are committed to commissioning high quality services from Wirral University Teaching Hospital NHS Foundation Trust (WUTH). We take very seriously our responsibility to ensure that patients needs' are met by the provision of safe, high-quality services and that the views and expectations of patients and the public are listened and acted upon. WUTH is an integral provider within the integrated care system and the C&M ICB commissioning model.

All NHS providers continue to face challenges following the global pandemic and industrial action and we would like to acknowledge the steps that have been taken by WUTH to deliver a quality service during 2022-23. We welcome the opportunity to comment on this account and believe it reflects the quality performance in 2022/23 and sets out forthcoming priorities for 2023/24.

We welcome the quality priorities set out for 2023/24 and acknowledge that the quality priorities not realised in 2022/23 are proposed to continue and expanded into the 2023/24 year to support development, sustainability and achievement of the key priorities outlined in the report. We will continue to monitor and review progress against these priorities and welcome the opportunity to work with the Trust to ensure the needs of the population are met.

Reducing Health Care Acquired Infections are vital in ensuring that avoidable harm does not occur to patients while in the Trust. Clostridioides difficile (C.difficile) and gram-negative bloodstream infections were highlighted as targeted improvement areas for 2022-23 and recognising the ongoing work by the trust and their engagement with the planned NHSE C.difficile system learning review and system wide Infection Prevention and Control meetings.

The national CQUINs (Commissioning for Quality and Innovation) system were reintroduced in 2022 as a means of challenge to trusts to ensure that quality and outcomes for patients are maximised. We acknowledge the performance reported for CQUINs as a true reflection within the account. There will be a continuation of monitoring and support to the CQUIN workstreams and welcome working closely with trust colleagues in achieving their 2023/24 CQUIN targets.

We acknowledge the Care Quality Commission response following their focussed inspection held in October 2021 and appreciate the challenges facing the Trust within the Urgent and Emergency Care Departments

There have been two Never Events during 2022-23. We are satisfied that they have been fully investigated and learning has been disseminated through the appropriate Patient safety routes, this is in line with the NHS Serious Incident Framework.

The trust has undertaken a large amount of preparation work to ensure compliance with the NHS National Patient Safety Incident Response Framework (PSIRF). This sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Cheshire and Merseyside ICB will continue to work closely with the Trust and other NHS organisations to progress the PSIRF in 2023 - 24.

We believe that this quality account gives an accurate account of the continuous quality improvements in Wirral University Teaching Hospital and the monitoring of the priorities in 2022/23. NHS Cheshire and Merseyside looks forward to continuing to work in partnership with the Trust to assure the quality of services commissioned over the forthcoming year.

Appendix Four: Statement from Wirral Metropolitan Borough Council

Following the implementation of Wirral Council's Governance arrangements including the migration from an executive to committee system, the Adult Social Care and Public Health Committee has been established for the implementation of the Authority's overview and scrutiny functions, as set out on Part 3 of the Local Authority (Committee System) (England) Regulations 2012. Comments were sought Councillor Janette Williamson as the Chair of the Committee and Party Spokespersons on the Wirral University Teaching Hospital (WUTH)Quality Accounts for 2022/23. Members were grateful for the opportunity to comment on the draft report.
Members firstly noted that it was difficult to provide commentary on the draft quality accounts for 2022/23 given the tremendous pressure the service area was under.

Members also noted that areas of focus and priorities for 2022/23 include developing a wellbeing culture across the trust as well as the delivery of first class, innovative Occupational Health and Wellbeing Services.

Members raised concerns about the take up by staff of the Flu Vaccine, querying why the take up of 54.54% was so low*. In regard to Quality and Safety within Emergency Departments and Trust Performance indicators, Members noted that the national standard for measuring performance is that 95% of patients should be seen within 4 hours and either admitted or discharged and noted the full year performance figures but queried the lack of detail and charts on this. Regarding performance indicators in general terms for the Trust, Members requested more explanation of how these will be met, going forward into 2024.

Also noted was wording such as 'partly achieved' and that the KPI's didn't seem to appear to allow for partial achievement. Whilst it is important to state what has been achieved, Members felt that it was equally important to be able to admit where targets had not been mat, and to provide a reason for this. The data indicates the KPIs were not achieved but they are described as partially achieved. It would also have provided more context to the report if all staffing levels, along with vacancies were provided in the preamble.

The Committee also intends to make sure that they will consult with patients, their families and patients' groups as part of its work in the coming year to hear directly from them so as to better understand the issues and challenges that face the service and the wider Wirral in tackling health inequalities.

The Chair and Party Spokespersons of the Adults Social Care and Public Health Committee would like to take this opportunity to thank the staff at Wirral University Teaching Hospital (WUTH) profusely for all work undertaken. The Adults Social Care and Public Health Committee look forward to continued partnership working with the Trust during the forthcoming year and note its priorities for 2022/23.

** Flu Vaccine compliance has been amended with final compliance of 62.5% and Trust achieved the second highest rate in Cheshire and Merseyside. However, we do acknowledge that as a Trust we want to see improvement and will strive to achieve the target next year of 80%.*