NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Quality Account

2025/26

together we will

...deliver the best quality and safest care to the communities we serve

Contents

Introduction

All NHS healthcare providers are required to produce an annual Quality Account to provide information on the quality of services they deliver.

We welcome the opportunity to outline how we have performed over the course of 2025/26, taking into account the views of service users, carers, staff and the public. This Quality Account outlines the work that had been undertaken during the annual reporting period, the progress made in improving the quality of our services and identifies areas for improvement.

As Wirral's largest employer, with more than 8,500 staff, the Trust provide a full range of acute, community and specialist services. With state-of-the-art facilities based within a fast-paced and ever-developing environment, this forward-thinking Trust is on an exciting journey of transformation in collaboration with Wirral Community Health and Care NHS Foundation Trust.

As our integration with Wirral Community Trust continues, our vision is simple but powerful: **together we will create healthier lives and stronger communities.**

The Trust operates from two main sites:

• Arrowe Park Hospital, Upton – delivering a full range of emergency (adults and children) and acute services for adults in the main hospital building. The Wirral Women's and Children's Hospital provides maternity, neonatal, gynaecology, children's inpatient, day case and outpatient units.
• Clatterbridge Hospital, Bebington – undertaking planned surgical services, dermatology services, breast care and specialist stroke and neuro rehabilitation services.
Outpatient services are provided from community locations including:
• St Catherine's Health Centre, Birkenhead – providing x-ray, community paediatric services, paediatric audiology and a range of outpatient clinics.
• Victoria Central Health Centre, Wallasey – providing x-ray, some outpatient services and antenatal clinic.
Seacombe birthing centre, Seacombe - providing midwifery led birthing options.
• GP practices, schools and children's centres.
Our full range of services include:
• accident & emergency services for adults and children
• a diverse range of acute and non-acute specialties
• outpatient services
• day surgery services
• maternity including a midwifery led unit
• diagnostic and clinical support services
• specialist services including:
  - renal medicine
  - dermatology
  - orthopaedics (hip & knee revisions)
  - ophthalmology (retinal)
  - urology (cancer centre)
  - stroke (hyper-acute unit)
  - gynaecology (advanced laparoscopic endometriosis centre)
  - neonatal level 3 unit and
  - Ronald McDonald House: charity home providing accommodation for parents of sick children and premature babies.

Clinical work is complemented and supported by a comprehensive range of corporate services, which include, amongst others:

- Governance support
- corporate nursing and midwifery
- operations and performance
- strategy and partnerships
- finance and procurement
- human resources and organisational development
- information and IT services
- facilities and estates management.

Statement of the Quality Account

Statement of the Quality Account: Janelle Holmes, Chief Executive Officer

The annual Quality Report for the organisation demonstrates how important quality and safety of patient care is to our organisation.

There has been continued high demand for our urgent and emergency care services this year with Emergency Department attendances at 94,555 compared to 93,130 the previous year. I'm delighted that the major redevelopment in our Urgent and Emergency Care Upgrade Programme will be completed this summer. That is the biggest development at Arrowe Park Hospital since it opened and will make a huge difference to the experience of patients who require urgent or emergency care.

We have commenced the integration with Wirral Community Health and Care and are also seeing the quality benefits of that through our joint working and sharing best practices.

The Quality Account recognises progress against all of the Trust quality priorities in 2025/26 including a continued focus on reducing Clostridium Difficile Infection (C.diff), looking at behaviours that challenge, and preventing deconditioning in patients.

Improvement work relating to C.diff resulted in a reduction in cases when compared to 2024/25 and this work continues. As part of the work looking into behaviours that change, the Trust launched a Violence Prevention and Reduction Plan which aims to prevent incidents, respond effectively to incidents, support staff post-incident, develop a reporting culture and align with NHS England's national framework. To prevent deconditioning in patients, a half day deconditioning workshop was attended by 80 staff; resources to reduce deconditioning were deployed across six wards; a deconditioning hub was set up on the intranet, and our Trust achieved national recognition with therapists showcasing work at a national conference.

The Quality Priorities for 2026/27 have been produced following a robust process to review learning from 2025/26. They have been co-developed with a wide range of internal and external stakeholders. The Qualities Priorities will be conducted jointly with Wirral Community Health and Care NHS Foundation Trust, with a focus on reducing harm related to five key clinical areas:

- Pressure Ulcers
- Falls
- Medications
- Discharges
- Infection prevention and control

As an organisation we participated in national and local audits in 2025/26, as we continuously drive to improve quality for our patients. We also participated in all of the national Confidential Enquiries applicable to the organisation.

We know that continued research leads to better outcomes for patients and it is great to see that our research portfolio has improved and will be looking at opportunities to capitalise on opportunities to undertake commercial research.

For the seventh year running our Endoscopy Team achieved Gold standard in the JAG Accreditation. This is a phenomenal achievement and a testimony to the hard work of staff.

We know that our workforce are key to driving improvements and it's important that they are encouraged to raise concerns. The Freedom to Speak Up Guardian role is prominent throughout the

organisation and there are a number of Freedom to Speak Up Champions, offering different opportunities for staff to raise concerns. As we continue our integration with Wirral Community Health and Care we will share best practice across organisations to enable us to make further improvements. Using insight from data, clinical knowledge, patients and public will help us deliver our Quality Patient Safety Enabling Strategy.

Janelle Holmes

Wirral University Teaching Hospital always aims to work in accordance with our Values.

Our Values

Caring: Acting with kindness, compassion, and empathy with everyone

Respect: Being honest and open, being polite and professional. Introducing ourselves by name. Treating everyone the way we wish to be treated.

Teamwork: Working within and across teams to provide the best possible quality of care and experience for our patients, families, carers and colleagues.

Improvement: Actively seeking new ways of working to enable improvement.

WUTH Strategic Framework – Our integration journey

In April 2026 we published our first joint Strategy 2026-32 in partnership with Wirral Community Health and Care NHS Foundation Trust. Developed following extensive engagement, our strategy is shaped by a changing national NHS landscape. The 10-year Health Plan, published in 2025, sets out an ambition to build a health service fit for the future through three major shifts:

- Moving care from hospital to community
- Accelerating the transition from analogue to digital
- Shifting the focus from sickness to prevention

Our strategy will strengthen neighbourhood and place-based partnership and use our digital and workforce strengths to deliver sustainable, person-centred care for the people of Wirral and further afield.

By uniting as one, we can strengthen services, tackle inequalities, and support the creation of a healthier future for our populations, evidencing that we are **Better Together.**

Better Together for people in our care

NHS

Wirral University Teaching Hospital NHS Foundation Trust
Arrowe Park Hospital
Arrowe Park Road, Upton CH49 5PE
Switchboard: 0151 678 5111

Wirral Community Health and Care NHS Foundation Trust
St Catherine's Health Centre
Derby Road, Birkenhead CH42 OLQ
Switchboard: 0151 514 2888

2. Priorities for Improvement

2.1 Update on Priorities for 2025-26

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

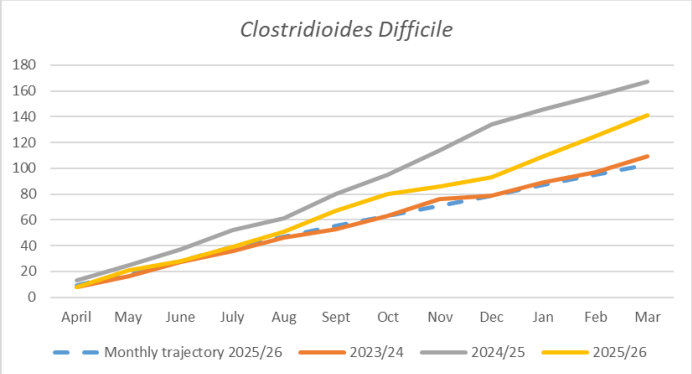
Quality Priority	*Success Measure*
Infection control – to include a continued focus on the reduction in rates of *Clostridioides difficile*	Achieve the standard contract threshold 25/26: Minimising *Clostridioides difficile*
Behaviours that challenge	Improved staff satisfaction demonstrated through the staff survey
Preventing deconditioning in patients	Increased number of patients who can sit out to do so

2.1.1 Infection control – to include a continued focus on the reduction in rates of Clostridioides difficile

Partially achieved

Work has continued within the trust during 2025/26 to reduce the cases of *C.difficile*, which relies upon appropriate antibiotic prescribing and advice, the earliest detection of possible *C.difficile* infection and prompt isolation of patients with diarrhoea. A rise in CDI has been observed nationally in recent years, particularly following the COVID-19 pandemic, the reasons for this are not fully understood and are being reviewed at a national level. In 2025/26 we have reported 141 *Clostridioides difficile* infections, this is a decrease of 26 infections when compared to 2024/25 but 38 infections over our annual threshold.

As in previous years, the NHS Standard Contract 2025/26 includes quality requirements for NHS trusts and Integrated Care Boards (ICBs) to minimise *Clostridioides difficile* (*C.difficile*) to threshold levels set by NHS England. The threshold CDI for WUTH in 2025/26 was set at 103. The Trust has exceeded this threshold, but it is pleasing to be able to report an improved position from 2024/25.



WUTH have taken the following key actions to improve this rate:

- Ensure prompt sampling to minimise the risk of transmission, implementing the Cheshire & Merseyside stool rule in all clinical areas and departments
- We have been an integral part of the implementation of a system wide CDI improvement plan with partners from across our local Integrate Care Board
- WUTH have participated in the *Clostridioides difficile* ribotyping network (CDRN) Sentinel Surveillance
- Promoted World Hand Hygiene Day in May 2025 and International Infection Prevention Week in October 2025
- Introduced a programme of IPC training for Facilities staff
- Delivered a prevent CAUTI campaign to reduce exposure to antimicrobials
- Developed a Bowel management newsletter for staff
- Supported Wirral Community Health & Care NHS Foundation Trust (WCHC) and Wirral Borough Council (WBC) with public facing messaging about *C.difficile*
- Introduced a weekday morning review of ED patients requiring single rooms
- Proactively managing recurrence by offering FMT to eligible patients
- Supported a programme of CSW training in ED

2.1.2 Behaviours that challenge

Achieved

Key Aims

1. Prevent incidents from occurring

This involves Cerner V&A risk flag rollout, Broset Violence Checklist pilot, Launch body-worn video (BWV) pilot in ED. Trust-wide communications campaign on prevention. Enhancing incident reporting controls and finalising Trust Violence Prevention Charter.

2. Respond effectively when incidents happen

To strengthen collaboration with Merseyside Police, including potential information sharing agreements. Develop a training strategy and TNA for Positive Behaviour Support. Review and refresh policies and escalation protocols.

3. Support staff post-incident

A staff support protocol will be designed and implemented. Peer support groups and staff networks will be actively promoted to strengthen staff wellbeing. An incident survey will be launched to capture both the emotional and operational impact of events. These measures will be aligned with the Patient Safety Incident Response Framework (PSIRF) to ensure a structured and consistent approach.

4. Develop a reporting culture

The “Respect and Protect” campaign will be delivered through lanyards, posters, screensavers, and public leaflets. The Staff Respect Charter will be displayed across all clinical and public areas to reinforce expected behaviours. Patients will be engaged through check-in kiosks, digital screens, and appointment

communications to ensure clear messaging. Staff rights and behaviour expectations will be reinforced during induction and annual training.

5. Align with NHS England's violence prevention framework

There will be monthly steering group meetings to track delivery and Biannual board reporting for assurance and oversight

Outcomes & Achievements:

Body-Worn Video (BWV) – Emergency Department

A trial of body-worn cameras in the Emergency Department commenced at the end of January 2026. Evidence from NHS and policing settings demonstrates that BWV can:

- Act as a visible deterrent to aggressive and violent behaviour
- De-escalate situations earlier through increased accountability
- Provide good quality evidence to support staff, investigations and police action
- Improve staff confidence and perceived safety during high-risk interactions The trial will be evaluated to inform a future Trust-wide approach.

Predictive Risk Tools – Broset Violence Checklist

A trial of the Broset Violence Checklist has been rolled out in high-risk clinical areas in October 2025. The tool supports early identification of escalating behaviours and provides staff with a structured, evidence-based approach to risk assessment. Anticipated benefits include:

- Earlier intervention and de-escalation
- Reduced likelihood of physical restraint or harm
- Improved consistency in clinical decision-making
- Enhanced multidisciplinary communication around risk
- Learning from the pilot will inform wider adoption.

Count of Reported Date Row Labels	Column Labels MSSW - Medical Short Stay Ward	Ward 21	Ward 22	Grand Total
Sep	2	18	12	32
Oct	1	1	3	5
Nov	0	6	1	7

Table above shows the number of incidents of V&A has significantly reduced since the Broset checklist was rolled out on the trial wards.

An Operational Violence Prevention Lead has been appointed to oversee all violence and aggression incidents, ensuring consistent review, appropriate action, staff support, and coordination with police.

Trust-wide communications and an updated Violence and Aggression Policy reinforce a zero-tolerance culture and clear behavioural expectations.

Staff engagement is being strengthened through planned Trust-wide sessions, while Positive Behaviour Support (PBS) training has been launched, with over 130 staff trained to promote proactive, person-centred approaches and reduce restrictive practices.

A performance dashboard is in development to provide real-time oversight of incidents, trends, and training compliance, alongside improvements to data quality through refinement of incident categorisation systems.

Progress and impact will be monitored through key outcome measures, including reductions in staff injuries, restraint use, and security calls, as well as improved compliance with post-incident processes and training.

2.1.3 Preventing deconditioning in patients

What is Deconditioning?

Deconditioning syndrome can be defined as the 'condition of physiological, psychological and functional decline that occurs as a result of complex physical changes', which happens with prolonged bed rest and the associated loss of muscle strength.

We know half of admitted frail older patients experience functional decline between admission and discharge, and up to 50% of older people can become incontinent within 48 hours of admission. In the first seven days of admission, inpatients have reduced muscle strength by up to 10%, reduced circulation by up to 25% and reduced dignity, quality, confidence, independence and choice.

National and international reports have shown how the pandemic adversely affected the physical, psychological and functional wellbeing of populations, with older people disproportionately affected by deconditioning.

There is evidence to share the findings of the negative impact of lack of movement due to inappropriately prolonged bed rest, so we can now change and establish an increase in activity in all patients – but more specifically, in older patients. There is now an urgent and growing need to shift focus from just avoiding deconditioning and to promote reconditioning.

The findings in favour of activity and exercise for older people confirm how important it is for us to identify effective approaches to behaviour change, to share the best practice and to put in place strategies to prevent deconditioning, at scale and speed.

The programme will build on previous improvement work and will use the IHI Collaborative Breakthrough Series to identify issues, support the development of PDSA's and measure impact. ***Focus Wards*** *- 10, 11, 24, 27, 36 and M1.*

Aim

To reduce physical deconditioning in patients by increasing daily movement, functional activity, and engagement throughout their stay.

Primary Drivers

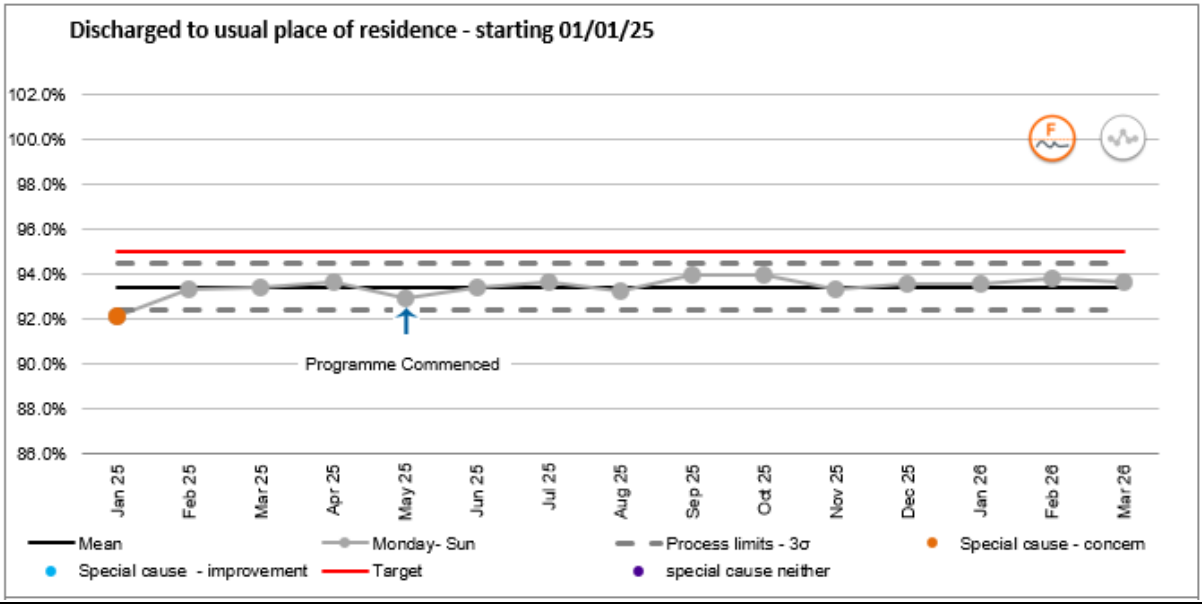
1. Early and frequent mobilisation
2. Patient and staff awareness of mobility goals
3. Consistent encouragement and support for activity
4. Reliable monitoring and prompting of activity

Metrics

Sentinel Metric

Number of patients discharged to their usual place of residence (whole hospital)

(an aspirational target of 95% for whole hospital)



Achievements

- Generated and tested ideas & resources to reduce Deconditioning across 6 words
- Held full day Deconditioning Workshop: Leading Care, Valuing Time attended by over 80 staff
- Developed Ward Change Bundle setting out best practice to be adopted across the Trust
- Reviewed & strengthened Deconditioning training offer: CSWs, Students, STOP, Impact & WEPP
- Built Deconditioning Hub webpages for staff including information, video & resources (patients' portal in progress)
- Achieved national recognition: Therapists presenting at National Conference to showcase work
- Recruited Volunteers to support ward activities and cognitive stimulation
- Sustainability and continuity in place – programme transferred to Corporate Quality Matron.

Reducing Deconditioning Change Bundle Poster

2.1.4 Quality Priorities 2026/27

In February 2026, the Trust in partnership with Wirral Community Health and Care NHS Foundation Trust jointly held a Quality Priority Event that provided an opportunity to showcase collaborative working and shared learning across both organisations. The event brought together colleagues from across acute and community settings, with each Trust presenting their achievements and impact against their 2025/26 quality priorities. This was followed by a facilitated workshop session involving key stakeholders, focused on shaping and agreeing the joint quality priorities for 2026/27. The priorities of falls, discharge, medication, and pressure ulcers were explored in depth, with discussion centred on system-wide challenges, opportunities for alignment, and areas where joint action could deliver the greatest impact for patients. The event was well attended, with around 60 participants from both Trusts and wider partners, including Healthwatch, and was positively received as a valuable forum for engagement, collaboration, and shared ownership of future quality improvement priorities. The general sentiment from those who attended was positive as evidenced by feedback below:

The Quality priorities agreed for 2026/27 are reducing patient harm in relation to the following areas:

- Pressure Ulcers
- Falls
- Medications
- Discharges
- Infection prevention and control

2.2.1 General Statement of Assurance

During 2025/26 Wirral University Teaching Hospitals NHS Foundation Trust provided and/or subcontracted the 91 relevant health services.

Wirral University Teaching Hospitals NHS Foundation Trust has reviewed all data available to them on the quality of care in all 91 of these relevant health services.

The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant Health Services by The Trust for 2025/26.

This year WUTH cared for:

	2024/25	2025/26
ED Attendances	93,130	94,555
UTC Attendances	36,616	36,746
Total	129,746	131,301
Births	2,896	2,777
Outpatient Attendance (all sites)	525,300	551,131
Inpatient Activity	65,067	61,864
Day Case Activity	52,774	51,637

2.2.2 National Audits

During 2025/26 the Trust participated in 97% (61/63) of National Clinical Audits applicable to Trust services. This is due to the wide range of Trust services with 63 out of a total of 88 national audits applicable to the Trust.

The Trust did not participate in 2 of the audits applicable to the Trust, however, participated in 100% of eligible National Confidential Enquires.

The National Clinical Audits and National Confidential Enquiries that Wirral University Teaching Hospital participated in during 2025/26 are as follows:

National Programme Name	Division	Should we Participate?	Case Ascertainment
British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	Surgery	Yes	100%
Evaluating the Management Pathway for Suspected Testicular	Surgery	Yes	100%

National Programme Name	Division	Should we Participate?	Case Ascertainment
Cancer Referrals (EMPAST)			
Breast and Cosmetic Implant Registry	Women and Childrens	Yes	100%
ICNARC Case Mix Programme (CMP)	Clinical Support and Diagnostics	Yes	100%
Child Health Clinical Outcome Review Programme1	Corporate	Yes	100%
Emergency Medicine QIPs - Adolescent Mental Health	Acute	Yes	100%
Emergency Medicine QIPs: Care of Older People	Acute	Yes	100%
Emergency Medicine QIPs: Time Critical Medications	Acute	Yes	100%
Emergency Medicine QIPs: Mental Health - Self Harm (RCEM)	Acute	Yes	100%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People1	Women and Childrens	Yes	100%
National Audit of Inpatient Falls (NAIF)	Medicine	Yes	100%
National Hip Fracture Database (NHFD)	Surgery	Yes	100%
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Corporate	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme1	Women and Childrens	Yes	100%
Medical and Surgical Clinical Outcome Review Programme1	Corporate	Yes	100%
National Diabetes Core Audit	Medicine	Yes	100%
Diabetes Prevention Programme (DPP) Audit	Medicine	Yes	100%
National Diabetes Inpatient Safety Audit	Medicine	Yes	100%
National Pregnancy in Diabetes Audit (NPID)	Women and Childrens	Yes	100%
National Diabetes Audit - Transition (Adolescents	Medicine	Yes	100%

National Programme Name	Division	Should we Participate?	Case Ascertainment
and Young Adults) and Young Type 2 Audit			
Gestational Diabetes Audit	Women and Childrens	Yes	100%
National Audit of Care at the End of Life (NACEL)1	Medicine	Yes	100%
National Audit of Dementia (NAD)1	Medicine	Yes	100%
National Audit of Metastatic Breast Cancer (NAoMe)1	Women and Childrens	Yes	100%
National Audit of Primary Breast Cancer (NAoPri)1	Women and Childrens	Yes	100%
National Bowel Cancer Audit (NBOCA)1	Surgery	Yes	100%
National Kidney Cancer Audit (NKCA)1	Surgery	Yes	100%
National Lung Cancer Audit (NLCA)1	Medicine	Yes	100%
National Non-Hodgkin Lymphoma Audit (NNHLA)1	Medicine	Yes	100%
National Oesophago-Gastric Cancer Audit (NOGCA)1	Medicine	Yes	100%
National Ovarian Cancer Audit (NOCA)1	Women and Childrens	Yes	100%
National Prostate Cancer Audit (NPCA)1	Surgery	Yes	100%
National Cardiac Arrest Audit (NCAA)	Corporate	Yes	100%
National Heart Failure Audit (NHFA)	Medicine	Yes	100%
National Audit of Cardiac Rhythm Management (CRM)	Medicine	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Medicine	Yes	100%
National Child Mortality Database (NCMD)1	Women and Childrens	Yes	100%
2025 Major Haemorrhage Audit	Clinical Support and Diagnostics	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Medicine	Yes	100%
National Emergency Laparotomy Audit - No Laparotomy	Surgery	Yes	100%

National Programme Name	Division	Should we Participate?	Case Ascertainment
(NELA)1			
National Joint Registry	Surgery	Yes	100%
National Major Trauma Registry	Acute	Yes	100%
National Maternity and Perinatal Audit (NMPA)1	Women and Childrens	Yes	100%
National Neonatal Audit Programme (NNAP)1	Women and Childrens	Yes	100%
Age-related Macular Degeneration Audit	Surgery	Yes	100%
Cataract Audit	Surgery	Yes	100%
National Paediatric Diabetes Audit (NPDA)1	Women and Childrens	Yes	100%
National Perinatal Mortality Review Tool	Women and Childrens	Yes	100%
COPD Secondary Care	Medicine	Yes	100%
Pulmonary Rehabilitation	Medicine	Yes	100%
Adult Asthma Secondary Care	Medicine	Yes	100%
Children and Young People's Asthma Secondary Care	Women and Childrens	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)1	Medicine	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Clinical Support and Diagnostics	Yes	100%
UK Cystic Fibrosis Registry - Children	Women and Childrens	Yes	100%
UK Interstitial Lung Disease (ILD) Registry	Medicine	Yes	100%
UK Parkinson's audit (Physio)	Clinical Support and Diagnostics	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Medicine	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Medicine	Yes	100%
National Pancreatic Cancer Audit	Medicine	Yes	100%

National Confidential Enquires into Patient Outcomes and Deaths (NCEPOD)

Study Title	Participation	Project Status	%
Acute Illness in people with a Learning Disability study	Yes	Submitted	75

Pleural Procedures	Yes	Submitted	44
Stabilisation of the critically ill child	Yes	In Progress	
Rib Fracture	Yes	In Progress	

Outcomes and Learning from Clinical Audits Undertaken During 2025/26

The number of clinical audits both national and local which formed part of the 2025/26 Audit Plan are as follows:

Total Number of Audits in 2025/26 plan	Number of Local/Other Audits	Number of National Audits 2025/26 Including NCEPOD	National Audits from Previous Year	Number of Audits Fully Completed
358	292	60	58	86

Some of the key learning from 2025/26 is as follows:

NCEPOD: New report - 'Endometriosis: A Long and Painful Road' - A review of the quality of care provided to patients diagnosed with endometriosis

Key Successes:

- Regular MDTs already in place, with plans to strengthen links with key services (physio, pain, mental health).
- Structured and safer clinical processes
- Comprehensive action plan completed for this

National Paediatric Diabetes Audit

Key Successes:

- Significant improvement in median HbA1c: 60.8 → 54 mmol/mol
- Significant improvement in tech usage: pump 46% →70%, HCL 23% → 46%
- Better than national average for:
  - Median HbA1c (56 mmol vs 60 mmol)
  - Proportion of pts meeting HbA1c target < 48 mmol/mol: (17% vs 12%)
  - Technology usage (pump 70% vs 55%, CGM 95% vs 81% and HCL 46% vs 36%)
  - Key health checks – esp improvement in urine and foot checks and overall in children over 12 years
  - Additional health checks – esp 4+ HbA1c; psych assessment; smoking status
  - Care at diagnosis (100% bloods & carb counting)
  - Improvement in macrovascular risk factors (BP and cholesterol)

Catching our breath: Time for change in respiratory care (NRAP)

Key Successes:

1. Improving data availability and quality to drive change

2. Delivering essential treatment on tobacco dependence. The Trust is above the national average in our dataset. 72% of asthma patients and 63% of COPD patients were offered tobacco dependency treatment compared to 70% and 65% nationally, respectively.

Emergency Laparotomy – Tenth Patient Report

Key Successes:

- Consultant-led care for high-risk patients remains consistently high, with 99% receiving direct involvement from both a surgeon and anaesthetist, supported by appropriate risk assessment.

National Early Inflammatory Arthritis Audit

Key Successes:

Recruitment, treatment and timeliness have improved

National Ovarian Cancer Audit

Key Successes:

WUTH demonstrated strong overall performance in ovarian cancer care

National Audit of Care at the End of Life (NACEL 2024)

Key Successes:

- Recognition of the dying process, or patients at risk of deterioration despite maximum treatment, appears to be improving
- Evidence of decision making and prescription of anticipatory medications from the notes
- High referrals to Specialist Palliative Care with proactive team and ward teams identifying patients who would benefit from input
- High levels of symptom control for pain and other physical symptoms reported
- Communication about the dying process improved and higher than national average
- Bereaved relatives were pleased with care and support they and their loved one received (83% and 81% respectively), rating WUTH as excellent or good
- Initial hydration assessments and recommendations at the end of life improving
- High levels of staff engagement in palliative and end of life care, with NACEL noting the numbers of staff surveys returned

Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People

Key Successes:

- Data for appropriate first assessment are improving year on year
- Very good nursing support and completion of care plans –Positive outlier report sent to the Trust
- Positive outlier for tertiary referral despite challenges with tertiary collaboration during this period
- Good evidence for safety planning
- SUDEP info is excellent

- Good evidence of ECG compliance increasing.
- Transition is improving steadily – especially with collaboration with ICU/MAU/ED colleagues and processes for CYP with medical complexity

National Oesophago-gastric cancer audit

Key Successes:

The results of the audit have shown that WUTH is above national average in:

- Data completed for patients seen by a CNS for all patient diagnosed, comparable with data recorded with complete CNS data.
- Number of patients diagnosed within 28 days of referral
- Number of patients treated within 62 days

NaoMe – audit of metastatic breast cancer at Wirral Breast Centre

Key Successes:

- High MDT Discussion Rate
- Excellent CNS Contact Rate
- Lower 30-Day Mortality (Recurrent)

Local Audits.

The reports and outcomes of 75 local clinical audits were reviewed within 2025/26 at directorate meetings.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Acute Medicine	ACU242503	Door to ECG Time to High-Risk Patients in ED (QIP)	• Improved ECG provision in ED has been shown to be achievable. • Initial simple interventions positively reduced booking-to-ECG times. • Faster ECGs should support quicker diagnosis and management of cardiac presentations.
Radiology - breast screening	CSD242501	Wirral & Chester breast screening Patient satisfaction survey 24/25	• Survey feedback was very positive, with 94% rating the service as excellent. • Improvements since the 2023/24 survey included: Better explanation of procedures, Improved explanation of compression and clearer communication on result turnaround times. • 2% of clients reported difficulty booking a convenient appointment time or venue. • Areas for review and improvement: Increase SCH survey response rates. Consider extended hours or weekend clinics and review clinic site locations. • Re-audit planned for 2025–26.
Radiology - breast screening	CSD242583	SQAS TP audit (Oct 2023-Oct 2024)	• 16,258 women screened • 332 repeats (2.04%) • Repeats: 293 qualified staff, 3 trainees

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Repeat rates below the 3% achievable target and below the 2% target for trained staff. Top three reasons for technical repeats: • Inadequate positioning • Blurring • Artefacts Formal action plan being developed for SQAS: • Regular re-audit and feedback of outcomes • Peer review sessions to discuss trends and provide improvement advice • Development of CPD sessions • Reminder for staff to review previous mammograms before examinations • Review images on PACS before the client leaves if blurring concerns are present • Improve techniques to reduce artefacts and blurring.
Radiology - breast screening	CSD252638	SQAS Partial Mammography rate audit	• WUTH partial rate: 0.298% • All cases were assessed, with 41 correctly classified as partials. • Findings are broadly in line with the previous audit. Common reasons for partials included: • Patients in wheelchairs • Implantable devices Documentation issues identified: • Not all partial annotations were recorded on Carestream (though all were documented on NBSS) • 14 cases annotated as partial without confirming PIL provision • 5 cases not annotated as partial at all Actions identified: • Remind staff to ensure correct annotation on Carestream and document PIL provision • Reinforce good positioning techniques for wheelchair patients • Reinforce effective patient communication • Ensure mammographers are familiar with guidance on partial/incomplete screening mammography Re-audit planned in 12 months.
Radiology - breast screening	CSD252639	SQAS Ceasing in the NHS Breast Screening Programme	Documentation findings: • 434 had ceasing documentation uploaded to BS-Select • 3 had documentation on NBSS only • 5 had no documentation on either BS-Select or NBSS Actions identified: • Upload missing documentation to BS-Select • Re-audit in 12 months.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Radiology - breast screening	CSD252640	Right Results audit	100% Compliance in all aspects of this review.
Radiology	CSC242561	Imaging in Acute Pancreatitis	Performance against standards: • Standard 2: 93.75% — indication for initial CT met criteria • Standard 3: 83.33% — CT report included all required aspects • Standard 1: 56.25% — initial CT performed at the optimal suggested time • Standard 4: 72.73% — ultrasound examination of the gallbladder completed within 24 hours Action identified: • Send communication to the surgical directorate reminding staff of the appropriate use of CT in the investigation of pancreatitis.
Radiology	CSD242512	Ultrasound assessment of axillary lymph nodes in patients with early breast cancer (re-audit)	• 52.8% of nodes with metastatic involvement were identified on pre-treatment ultrasound, meeting the ≥50% target. • 100% of patients underwent ultrasound-guided needle sampling. • Fine needle aspiration (FNA) appeared more accurate for diagnosing metastatic involvement, although study numbers were small. • Standard 4: 72.73% received gallbladder ultrasound examination within 24 hours. • Re-audit planned for December 2025.
Radiology	CSD242575	Neuroimaging in suspected physical abuse	• Good compliance demonstrated for CT and skeletal survey requests in suspected non-accidental injury (NAI) cases. • 21/21 (100%) index cases received CT head and skeletal survey imaging. • 19/21 cases had skeletal surveys completed within the recommended 24–72 hour timeframe following CT head. • 22/22 patients (21 index cases and 1 sibling) received follow-up skeletal surveys within the recommended 28 days. • 18 follow-up skeletal surveys were completed within the ideal 14-day timeframe. • One twin sibling underwent imaging but did not receive a CT head. Actions identified: • Increase awareness of the imaging pathway in suspected physical abuse cases • Ensure copies of guidelines are available in Radiology, ED, and Paediatrics for reference.
Radiology	CSD252660	Biopsy Request Re - Audit Report Jan -Sept 2025	• Generally high levels of compliance were demonstrated during the re-audit. • Of 50 requests audited, 10 biopsy requests did not specify which side was to be biopsied, sometimes because there was no preference.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Some cases showed laterality and location documented in the wrong field or omitted entirely. • Further education for requestors is required, with dissemination by the Clinical Lead. • Re-audit planned in 6 months to assess improvement.
Radiology	CSD252658	The success of imaging guided renal biopsy procedures	• Reporting compliance was exemplary, with 100% of cases meeting required descriptors. • Approximately 10–12% of specimens were non-representative, particularly in cystic or complex lesions. Actions identified: • Continue current practice and maintain existing protocols, which meet safety and efficacy standards • Explore methods to reduce non-representative specimen rates • Investigate strategies such as real-time pathology feedback, especially for complex and cystic lesions.
Radiology	CSD252657	An audit of image guided percutaneous lung biopsy to evaluate results in terms of sample adequacy for histological diagnosis and for safety.	• A single protocol deviation was identified and corrected immediately, with no compromise to diagnostic accuracy. • Pneumothorax rate was 34.3%, with 9.0% requiring drainage — both above BTS standards. Higher complication rates were associated with: • Larger lesions • Multiple biopsy passes • Spiculated or ground-glass lesions • Necrotic, mixed, or cavitating lesions Actions identified to reduce pneumothorax risk: • Careful pre-procedure planning for spiculated lesions • Limit the number of passes where feasible without reducing diagnostic yield • Stricter post-biopsy monitoring for high-risk patients • Re-audit planned within 12 months to assess the impact of interventions.
Radiology	CSD252650	An audit of imaging in suspected cauda equina syndrome against national GIRFT recommendations	• 75% of scans were supervised, and 80% of unsupervised scans included the correct sequences. • Only 3 patients required further neuroaxis imaging. • The new GIRFT scanning process improved patient flow and management by reducing delays and unnecessary inpatient stays while awaiting tertiary centre advice. • Just over 50% of MRI scans were performed within 4 hours.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Further improvement is challenging without provision of 24/7 MRI cover. Further actions identified: • Improve supervision rates for scans • Ensure correct sequences are performed during unsupervised scans • Remind consultant radiologists and MRI department staff of requirements.
Radiology	CSD252648	Uterine Fibroid Embolisation (UFE) Technical aspects audit - Assessing the departmental provision of Uterine Fibroid Embolisation	• 100% of patients had a pre-procedural MRI. • 100% of treated patients had no contraindications to the procedure. • 100% had a completed consent form. • 96% had a completed WHO surgical safety checklist. • 100% of procedures had a low screening time (<90 minutes). • 89% of recorded doses were below the recommended dose level. • 80% of patients had an admission duration under 30 hours (standard: <24 hours). • 56% of patients saw a radiologist in an outpatient setting. • Technical success rates varied from 4% to 68%. • 72% had dose information saved on procedure images. • 80% had follow-up documented in the notes (standard: >90%). Actions identified: • Ensure pre-procedural patient discussions are documented • Ensure follow-up decisions are documented • Ensure dose data is correctly saved to procedure images.
Radiology	CSD252645	Quality of special care baby unit (SCBU) portable chest X-rays	100% compliance achieved for: • Correct referrer entered on RIS • Visualisation of nasogastric tube tip • Dose correctly recorded on RIS and within local DRL • Anatomical marker included in the primary beam Actions identified: • Provide feedback to SCBU, Paediatrics, and Radiographer teams • Ensure correct positioning of babies and maximise image coverage • Prevent objects overlying relevant anatomy during imaging • Maintain clear visibility of NG tube tips to confirm placement • Continue making X-ray dose information available on RIS for monitoring

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Provide teaching/simulation sessions for radiographers to improve image quality • Encourage reporting radiologists to highlight unsatisfactory images to radiographers Re-audit planned after changes in 3 months, with an interim re-audit in 3 weeks to monitor progress.
Radiology	CSD252643	An audit of compliance with the British Society for Haematology (BSH) guideline for the use of imaging in the management of patients with myeloma	100% compliance achieved for: • Whole-body imaging (MRI/CT/PET-CT) in suspected myeloma with or without MDE • Whole-body MRI in oligo-secretory myeloma • PET-CT or whole-body MRI for suspected solitary plasmacytoma assessment • Repeat imaging in suspected relapse Standard 4 compliance: • MRI whole spine reported within 24 hours in suspected cord compression among myeloma patients — 50% compliant Actions identified: • Share findings with Haematology • Consider limited-sequence MRI if scanning capacity remains an issue • Update Cerner to prevent future requests for skeletal survey X-rays in myeloma screening • Hold discussions with radiographers, haematologists, and management regarding a business case for whole-body MRI provision
Radiology	CSD252634	Fluoroscopy WHO checklist Q3	• All sections achieved 100% compliance. • Staff appeared comfortable using the checklist • Diabetic patients monitored after steroid injections showed fluctuations in glucose readings. Actions identified: • Share audit results with staff and maintain high compliance levels • Move to online WHO forms in October 2025 • Inform diabetic patients about possible glucose fluctuations following steroid injections • Provide staff education on the importance of documentation.
Radiology	CSD252632	MRI WHO Checklist Q3	• High compliance demonstrated, with 6 of 7 audit questions achieving 100% compliance. • The time-out process was not completed in 2 of the 3 audited cases. • Morning huddles will now include allocation of roles for emergency situations. • Nitrous oxide has been added to the WHO checklist, along with associated safety precautions. Action identified: • Remind MRI, Anaesthetics, and Recovery staff to complete sign-out on Cerner.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Radiology	CSD252626	Audit of IR(ME)R Employers Procedures compliance - IR Q4	100% compliance achieved for: • Justification • Patient identification (ID) • Documentation on Cerner • Last menstrual period (LMP) recording • Dose results recording Actions identified: • Reinforce importance of correct documentation • Continue quarterly audits for robust process monitoring and real-time oversight • Continue reinforcing compliance messages through staff meetings after each data collection period
Radiology	CSD252625	Audit of IR(ME)R Employers Procedures compliance - Breast Q4	100% Compliance in all aspects of audit: Re-audit (quarterly) Remind staff of need to comply with process and share results.
Radiology	CSD252624	Audit of IR(ME)R Employers Procedures compliance - CT Q4	100% compliance in all areas audited (Justification, ID, LMP and dose results). This is in keeping with the previous 3 audits. • Repeat audit quarterly • Reinforced message to comply with process introduced via staff meetings following each data gathering period.
Radiology	CSD252623	Audit of IR(ME)R Employers Procedures compliance - X-ray & Fluoroscopy Q4	• 100% compliance achieved across all five areas (Justification, ID, IPS, Exposure Factors, and DAP), maintained from previous audit. • Data collected from all WUTH sites, including CDC, increasing departmental assurance. • Expanded dataset of 100 examinations, with compliance still sustained. • Increased audit volume due to newly installed fluoroscopy equipment. • Ongoing education supported through daily huddles and monthly newsletters. Actions identified: • Cascade audit results to staff and reinforce the importance of maintaining 100% compliance • Continue re-auditing to ensure sustained performance.
Therapies	CSD242572	Impact of spinal Advanced Physio Practitioner problem solving session with WCFT spinal physio team.	• Significant reduction (95%) in email queries, staff now have a protected 30 mins a week for WCFT queries. • 50% reduction in WCFT referrals into MCAS, thus reduced MCAS wait times. • Excellent staff feedback regarding the sessions. • High discharge rate and continue physio rate Actions: • Feedback audit outcome to WCFT staff and B8a WUTH physios.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Look at reasons why patients were discharged/referred to continue physio. • Discuss if any training needs for WCFT staff remain unfulfilled
Therapies	CSD242577	To explore the impact of adequate analgesia and the effect it has on timely patient discharges from ED	• Patients admitted to ED with moderate or severe pain should receive analgesia within 15 minutes of arrival. (Royal College of Emergency Medicine) Compliance: 0% • All ED patients in severe pain should have the effectiveness of their analgesia reviewed every 15 minutes (Royal College of Emergency Medicine) Compliance: 0% • Patients admitted to a hospital setting with pain should have their pain assessed using a pain scale with analgesics provided and adjusted as needed. (NICE) Compliance: 0% Actions: To promote the importance of accurate pain assessments and management of acute pain to ED staff including doctors and nursing staff
Pharmacy	CSD252675	Assessing Trust Compliance of Documenting Initiation of Gabapentinoid Medication and their Rationale and Follow Up Plan on Discharge Summaries following Hospital Admission	• 72% (89/124) of patients discharged on a gabapentinoid were at increased risk of falls according to NICE guidance. • 9 patients (7.3%) were newly started on a gabapentinoid during admission. • Follow-up data (available for 6 patients) showed 5 remained on gabapentinoids 3 months post-discharge. • Identified need for improved discharge communication regarding follow-up requirements. Actions identified: • Present findings at clinical pharmacy meeting, focusing on polypharmacy and gabapentinoid risks in patients at risk of falls • Initiate a chronic pain pharmacy MDT.
Pharmacy	CSD252611	Oxygen Audit	• Medicine division was the highest performing, with 74% compliance in oxygen prescribing. • Critical care achieved 83% compliance, supported by higher staff-to-patient ratios. • Ward 38 showed strong performance with 87% compliance and the highest number of patients on oxygen. • Trustwide, 40% (37/93) of patients received oxygen without a prescription, an increase from 29% in the 2023 audit. • Admissions division had the lowest performance, with 80% of patients receiving oxygen without a prescription (worsened from 20% in 2023). Actions identified: • Audit results disseminated to divisions and escalated to PSQB

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Agreed at PSQB to re-audit in September 2025 and then finalise an improvement plan.
Pharmacy	DSC2425101	Compliance with IV iron only being used after 3 months trial of oral treatment	• Consent was correctly obtained • Highlighted the need to review the trust guideline, prescribing process, and overall management of Ferinject in maternity services. • Only 21% completed a 3-month oral iron trial • Non-standardised use of Ferinject, with IV iron guideline not consistently followed • 100% of cases had incomplete administration documentation, leading to errors in ward records • Inconsistent diagnostic testing (ferritin checked in 50%, iron in 39%) • Late pregnancy administration often due to failed oral iron therapy or poor follow-up • 13 cases showed poor midwifery engagement Actions identified: • Present audit findings to obstetric clinicians and wider team • Review and update the current trust guideline • Work with pharmacy informatics to explore integrating IV Ferinject prescribing into Wirral Millennium system
Pharmacy	DSC2425100	Pharmacist Intervention Audit	• 590 pharmacy interventions recorded in the one-day audit, compared with 486 in the 2017 audit. • 47 major interventions identified, generating an estimated £47,000 in cost savings (ScHaRR model). • 50% (297/590) of interventions involved critical medicines. • 68% (201/297) of critical medicine interventions related to anticoagulants or antimicrobials, both high-risk areas. Actions identified: • Re-audit planned to assess impact of reduced pharmacy service availability • Consider adding anticoagulants and antimicrobials to the risk register and undertake further focused audits.
Pharmacy	DSC242599	Post natal TTHs enoxaparin not being collected	• 100% of patients received discharge medication within 24 hours, preventing missed doses. • 40% of post-natal VTE assessments were inaccurate on review. • Most common issue was omission or incorrect recording of BMI. Actions identified: • Involve a specialist pharmacist in training on VTE assessment completion and thromboprophylaxis prescribing

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions

			• Address discrepancies between Trust guidance and the VTE assessment tool in Cerner
			• Options under consideration:
			  ○ Update the Cerner tool to remove discrepancies
			  ○ Or update the guideline to reflect discrepancies and ensure future system compatibility.

Pharmacy	CSD252671	Controlled Drugs Storage and Security (Q3) 25/26	• Overall good compliance with CD keys and security standards • Key issue identified: CD keys were not always held separately on their own lanyard, reflecting a recent policy change requiring further reinforcement. • Record keeping and governance showed generally good compliance • Accuracy of individual CD register entries • Correct process for amending erroneous entries • CD cupboard contents were appropriate, with most stock in date and balances correct. • Rescue medicines compliance was high with Naloxone available in all areas & Flumazenil available in all but one relevant area. • Patient's Own Controlled Drugs were well managed, with correct balances in all but two cases. • 19% (15/79) of areas did not keep CD keys as a separate set of keys. • 19% (15/79) of areas did not follow correct standards for correcting register errors. Actions identified: • Clarify CD key storage requirements across wards • Reinforce correct CD register amendment procedures • Next audit scheduled for January 2026, including reassessment of CD key separation compliance.
Pharmacy	DSC242596	VTE prophylaxis - Trustwide Audit of Compliance with Policy	• Notable improvement in administration time within 14 hours of prescribing; however, full compliance was not achieved. Actions identified: 1. Disseminate re-audit results and highlight the key themes requiring improvement. 2. Prioritise improving compliance with consultant-led VTE assessments within 27 hours of the decision to admit, as this standard demonstrated the lowest performance. 3. Support and strengthen education around appropriate prescribing of VTE prophylaxis.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Pharmacy	DSC242555	A Review of Prescribing, Administration and Replenishment of Continuous Infusions	• 100% compliance (63/63 infusions) achieved for nursing staff signing the MAR chart. • 65% (32/49) of patients prescribed continuous infusions commenced treatment within 2 hours of prescribing. • 82% of continuous infusions were replenished within 60 minutes once the bag/syringe was completed. Actions identified: 1. Define clear standards for what constitutes a delayed versus missed dose. 2. Review Cerner MAR/Care Compass functionality to improve visibility of continuous infusion administration tasks. 3. Develop BI Portal dashboard reporting for real-time monitoring of missed or delayed doses. 4. Educate staff on the importance of documenting delayed doses clearly. 5. Re-audit to identify contributory factors for delayed infusions. 6. Review MAR delayed-dose recording options. 7. Explore pump-tracking technology to improve access to spare devices. 8. Review and streamline pump ordering processes if required. 9. Remind prescribers to communicate prescribing decisions promptly to nursing staff. 10. Reinforce that non-titratable continuous infusions must be re-prescribed following dose changes. 11. Standardise Trust handover processes to ensure medicines and infusions are consistently discussed. 12. Produce and disseminate a MedSafetyBite via the Safety Bus. 13. Include the importance of continuous infusion handover in staff training presentations. 14. Engage with the Intravenous Access Team regarding standardised criteria for additional cannulae. 15. Remind staff to plan ahead for insertion of additional cannulae when continuous infusions are prescribed.
Pharmacy	DSC242598	A Service Evaluation of How Many Patients with Inflammatory Bowel Disease (IBD) Are Switched to Subcutaneous Vedolizumab Following Initial Intravenous Loading Doses	• Of 102 patients reviewed, 74 continued to receive IV Vedolizumab following the 12-week review. • Of these 74 patients, 62% (46/74) were identified as suitable for switching to subcutaneous (SC) Vedolizumab via homecare. Actions identified: 1. Revise the 10-week review recommendation following discussion with the IBD team.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			2. Update the pathway to reflect current demands within the IBD service. 3. Provide education to the Gastroenterology team on SC biologic therapies. 4. Improve patient education, including implementation of patient information leaflets. 5. Expand the pathway approach to include other biologics, such as infliximab.
Pharmacy	DSC242597	Assessing Trust Compliance of Documenting Medication Changes and their Rationale on Discharge Letters following Hospital Admission	• Gold standard compliance improved Trust-wide from 19% in 2022 to 35% in 2025, demonstrating better documentation of medication change rationale within the correct discharge letter sections. • 34% of discharges failed to meet any documentation standards for medicines stopped, started, or changed, against an expected compliance of 0%. • Bronze standard compliance (medicines stopped/started documented without rationale) was 66% Trust-wide versus an expected 100%. • Silver standard compliance (medicines stopped/started/changed with rationale documented, but not in the correct section) was 47% Trust-wide against an expected 100%. • Gold standard compliance (medicines stopped/started/changed with rationale documented in the correct section) was 35% Trust-wide against an expected 100%. Actions identified: 1. Communicate audit results and actions to Pharmacy staff at the clinical staff meeting. 2. Present audit findings at relevant divisional meetings, including: o Adult Medicine Quality Board o MSOP o Surgical Quality Board 3. Review the discharge policy to clarify responsibility for each section of discharge letter completion, with discussion at the Pharmacy Clinical Quality and Safety meeting. 4. Explore opportunities for secondary care pharmacists to work alongside primary care colleagues to better understand the impact of incomplete discharge letters. 5. Reconsider Cerner functionality solutions to support medicine review during discharge letter completion.
Pharmacy	DSC242554	Assessing the appropriateness of newly initiated opioid	• Of 111 prescriptions reviewed, 87% (97/111) advised that newly initiated opioids should not continue after discharge.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
		discharge plans on surgical wards	• Six patients were discharged on modified-release (MR) opioids; 67% (4/6) complied with rib fracture guideline duration recommendations. • Only 48% (53/111) of prescriptions included a recommended opioid duration. • Of the 14 prescriptions where opioids were intended to continue after discharge, only 43% (6/14) recommended GP review. Actions identified: 1. Present audit findings to relevant surgical staff & pharmacy 2. Explore adding prescribing prompts for opioids (including codeine and tramadol) within discharge prescriptions to ensure course length or review dates are documented.
Pharmacy	DSC242548	Audit of The Safe Use Of Intrathecal Chemotherapy (24)	• Storage compliance improved from November 2024 following installation of a lockable cupboard. • 100% compliance was achieved across 13 of 16 audit standards. • Intrathecal storage was non-compliant until late 2024 due to the previous storage area not being lockable; this has now been rectified. • No patient harm was reported from any clinical incidents. • The target of zero clinical incidents was not achieved, with two incidents reported; these provided important learning points to reduce recurrence. • LOCSSIP compliance was 76%, with several forms containing missing fields or unchecked safety boxes. This was an additional KPI introduced for the year. Actions identified: 1. Update the LOCSSIP process to ensure all materials used for administration, including needles, are checked to confirm they are in date following the April 2024 expired needle incident. 2. Highlight LOCSSIP non-compliance to staff involved in administration and administration checks to improve completion and safety compliance.
Pharmacy	DSC2425102	Evaluation of chemotherapy prescriptions requiring pharmacist intervention	• Highlights the important role of haematology pharmacy team in safety-netting prescriptions and identifying issues within this high-risk area. • 57% (79/139) of prescriptions required pharmacist intervention, consistent with the 2022 audit result of 58%, indicating no improvement in prescribing practices.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• The average number of pharmacist interventions per prescription increased to 1.7, compared with 1.4 in the previous audit. • 47% (102/216) of identified errors were considered clinically significant and would likely have impacted patient care without pharmacist intervention.
Pharmacy	DSC2425103	5 year follow up of patients on letrozole for treatment of breast cancer in Healthier West Wirral	The findings emphasise the need for enhanced monitoring protocols, better communication between oncology specialists and primary care providers, and improved adherence to bone health management strategies.
Critical Care	CSD242572	CMCCN Relative satisfaction survey	Overall all really good feedback received by the unit. Remind staff to give out written information (complete)
Blood Sciences	CSD252641	Detection and management of hypertriglyceridaemia induced pancreatitis	• Lipid testing on admission was low at 13.2%. • Only 35.9% of patients received lipid testing at any point during admission. • Confirmed hypertriglyceridaemia (HTG) cases accounted for 2.4% (4 cases). • Referral processes for HTG management were inconsistent. Actions identified: 1. Implement an automated reflex process to add lipid profiles to significantly lipaemic samples. 2. Promote the Lipid Clinic Service to surgical and acute teams. 3. Deliver education sessions for ED, AMU, and surgical teams on recognising HTG. 4. Publish a short guideline on triglyceride-related pancreatitis on the Trust intranet. 5. Repeat the audit within 12–24 months
Therapies	CSD252651	To Assess the Compliance of the SOP 'the Commencement of First-line Oral Nutritional Supplements for Inpatients' prior to Dietetic Assessment	• 69.6% of respondents were aware of the ONS SOP. • Respondent confidence in knowing when to implement and follow the SOP was variable. • Key barriers identified included education and communication challenges, particularly relating to time and resource constraints. • Concerns were raised regarding provision and duration of Ensure shakes. • Issues were identified with the adequacy of the referral system. Actions identified: 1. Provide education to support ward colleagues regarding FRC. 2. Identify a Nutrition Champion on each ward using a "train the trainer" approach. 3. Review and implement improvements to the electronic dietetic referral system. 4. Undertake patient risk assessments 5. Complete a re-audit

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Therapies	CSD252670	Audit of the 2025 bicarbonate prameters for haemodialysis patients attending WUTH and on home haemodialysis	• Targets for haemodialysis patients were achieved across three months, with compliance rates of 63%, 62%, and 56%. Actions identified: 1. Incorporate updated guidance promoting five portions of fruit and vegetables daily into routine practice 2. Developing a SOP to support greater autonomy in adjusting haemodialysis bicarbonate levels 3. Introduce "focus of the quarter" educational topics at APH to strengthen patient education on dialysis
Radiology	CSD242582	Assurance that patients who are referred for ultrasound of the axilla are imaged in the correct department (Re-audit)	• It is acknowledged that no patient referrals were incorrectly accepted in error. • No further errors from this audit have been identified and vetting sonographers/consultants are following the SOP. • Of the 10 scans that were correctly rejected and referred to the Breast unit, 2 had pathology identified.
Radiology	CSD252653	Radiological Guidance for the Recognition and Reporting of Osteoporotic Vertebral Fragility Fractures (VFFs)	• High compliance (98%) in reporting bone integrity was achieved. • Correct terminology was consistently used • There was underestimation of moderate and severe fractures. • No recommendations or alerts were provided for follow-up or referral. Actions identified: 1. Consider implementing a vertebral fragility fracture (VFF) alert system (automated or manual) to notify clinical teams of new fractures. 2. Reinforce use of Genant grading, including documentation of degree of vertebral height loss in reports. 3. Disseminate audit findings to raise awareness across radiology services. 4. Re-audit following implementation of changes to assess improvement.
Radiology	CSD252649	Adequacy of clinical information on multidetector computed tomography (MDCT) requests for adult patients presenting following major trauma	• 81% cases included mechanism of injury and primary survey findings. • 71% cases reported within time frame as per standard 12 (1 hour of MDCT).
Radiology	CSD242589	WUTH Ultrasound Gallbladder polyp surveillance	• 65% of scans with gallbladder polyps <5mm were correctly included in follow-up. • 100% compliance was achieved for correct follow-up of polyps measuring 5–9mm at appropriate re-scan intervals.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• 100% of polyps >10mm were correctly referred to upper gastrointestinal (UGI) services. • Only 2% of reports included formal follow-up recommendations, with most follow-up decisions made by the requesting clinician. • 69% of reports without follow-up recommendations still met criteria where a recommendation may have been beneficial. • 42% of reports without UGI referral recommendations met criteria for referral. • 35% of asymptomatic GB polyps <5mm already on follow-up were followed up incorrectly. Actions identified: • Present findings at audit meetings. • Implement gallbladder polyp alert/recommendation system in ultrasound reporting (now in place). • Re-audit to assess improvement
Cell Path	CSD252655	Lymphovascular Invasion (LVI) in breast cancer excision	100% compliant with RCPath standard that all reports had a comment on LVI presence. 21% of breast cancer resections were LVI positive (in line with recorded incidence of LVI in other studies). Re-audit in 12-24 months.
Cell Path	CSD252646	An audit of breast cancer grading	• 100% compliance achieved for breast cancer grading. • 86% concordance between biopsy and resection specimen grades, exceeding the expected 70% standard. • Grade distribution in screening cases closely matched expected distributions. • In symptomatic cases, grade 1 distribution was well aligned with expectations, but there were more grade 2 and fewer grade 3 cancers than expected. Actions identified: • Re-audit in 12 months • Conduct a blinded internal audit to assess consistency of grading between breast pathologists within the department.
Microbiology	CSD242529	Re-Audit on clinical authorisation of General Wounds/Fluids/Tissue culture results	• Major errors: 0% (100% standard met). • Moderate errors: 0% (90% standard met). • Minor errors reduced from 54% to 31%, showing a significant improvement compared with the previous audit. Actions identified: • Share audit findings with laboratory and medical microbiology staff. • Acknowledge laboratory staff for high-quality work and improvement since the last audit. • Review SOP regarding unnecessary comments.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Re-audit to reassess compliance and adherence to the SOP.
Gastroenterology	MED252642	Audit of the current usage of the abdominal paracentesis LOCSIPP within the MDU	• Specialist nursing team effectively delivers paracenteses within the Medical Day Unit. • Consistent documentation of procedure indications was observed. • High engagement with LocSIPP safety processes following targeted education • Sustained improvement in LocSIPP completion, achieving >90% compliance. • Simple, low-cost interventions (education and visual prompts) were effective in improving practice. • Strong multidisciplinary collaboration across hepatology, anaesthetics, and IT teams. • Development underway of a Trust-wide electronic LocSIPP to support long-term sustainability. Actions identified: • Continue use of visual prompts and reinforce LocSIPP completion during team handovers. • Implement an electronic LocSIPP PowerForm within Cerner Millennium. • Re-audit after digital integration to evaluate documentation quality.
Gastroenterology	MED 252640	RAMONA audit - Refractory ascites management and outcome	• 100% of patients had access to the medical day-case unit • 100% of patients were appropriately referred for transplant, TIPS, or palliative care involvement. • Significant delays were identified in some palliative care referrals, with waits exceeding 100 days. • Documentation of discussions regarding TIPS was inconsistent or missing. • One patient received a long-term ascitic drain (LTAD) without prophylactic antibiotics, contrary to Trust guidelines. Actions identified: • Increase ward staff familiarity with LTAD management. • Present findings at audit meetings to raise awareness.
Gastroenterology	MED242536	Audit to support compliance with NICE Guideline - NG50. Cirrhosis in Over 16s: Assessment and Management	• 81/90 patients were offered FibroScan; 8 patients were diagnosed with cirrhosis via biopsy or imaging and did not require FibroScan. • 88/90 patients were appropriately on hepatocellular carcinoma (HCC) surveillance; 2 were not due to frequent DNA (did not attend).

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• 69/90 underwent varices surveillance OGDs; 12 did not meet criteria (Baveno) and 9 declined. • Varices management in 69 patients: 24 received carvedilol, 4 had banding, and 41 required no intervention. • Only 5/90 patients were on carvedilol for primary prevention of decompensation, indicating an area for further review. • 81/90 patients had no upper GI bleed; 9/90 were appropriately treated for upper GI bleeding. Actions identified: • Further audit and discussion required regarding primary prevention of decompensation with carvedilol. • Separate audit needed to properly assess SBP prophylaxis practice in stable outpatient cirrhosis patients.

Cardiology	MED242533	Monitoring for hypophosphataemia in patients receiving intravenous Iron infusion	• No patients experienced life-threatening clinical presentations, even in cases of severe hypophosphataemia.
			• The audit confirmed the presence of hypophosphataemia risk associated with treatment, consistent with prior MHRA safety concerns (2020).
			• The primary aim was to confirm and highlight the existing risk to support safer practice and guideline development for ferrous carboxymaltose (Ferinject) use.
			Actions identified:
			• Update heart failure and transition team guidance for Ferinject to include:
			  ○ Clear information on the risk of hypophosphataemia
			  ○ Requirement to check baseline phosphate levels alongside other pre-treatment blood tests.

Cardiology	MED242544	ACS WUTH patients transfer to LHCH - What is the delay?	• The cover for cardiology in reach to ED requires further review.
Cardiology	MED242543	Smoking Cessation advice to patients in cardiology	• Smoking history documentation is more consistently recorded in ED compared with ward-based documentation. • Nursing proformas support smoking history capture, but this is less consistently reflected in ward round notes. • Documentation of smoking cessation advice and discussions is present • Multiple smoking cessation support methods are available, including leaflets and local cessation services.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Performance compares favourably with national data (BTS smoking cessation audit 2019), where only 22% of inpatient smokers on a cardiology ward were offered cessation support.
Respiratory	MED242542	6199 EBUS	• Should be doing more staging ebus- dual referrals with: CT biopsy Sampling more nodes Documenting sonographic characteristics Sending more tissue PET availability prior to ebus Action to Re-audit
Respiratory	MED242554	6216 Constipation and opioids	• 35 patients were assessed in total (2 excluded due to end-of-life care). • 22/35 patients (63%) were prescribed opioids. • 17/22 patients (77%) receiving opioids were co-prescribed laxatives. • Compliance improved over the audit period, increasing from 77% to just over 80% Actions identified: • Need identified to standardise opioid prescribing to ensure automatic inclusion of laxatives. • Ongoing discussions with pharmacy team regarding development of an Electronic Patient Record order set for opioid prescriptions including laxatives.
Rheumatology	MED242546	6203-Audit of WUTH GCA service and to update WUTH GCA pathway	• 40% referrals had normal inflammatory markers • Use of TAB as diagnostic tool could be lengthening time of steroid exposure (wait for procedure, then wait for result) Actions identified: • Importance of risk assessments and counselling patients
Haematology	MED242555	UKONS 24 hour triage line	• The triage line continues to provide significant benefit, helping prevent unnecessary ED attendances through timely advice and guidance. • Patients referred to ED were appropriate, with reduced inappropriate attendance. • Call volumes have decreased, suggesting improved early advice, assessment, and patient support throughout their care pathway. • 71% of patients advised to attend ED were subsequently admitted, supporting the appropriateness of clinical triage decisions. • The remaining 29% required urgent care, received treatment, were stabilised, and were discharged. • A dedicated bed on Ward 30 has been introduced to enable direct patient review

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			and coordinated care, aiming to further reduce ED attendances. • Overall triage line calls have decreased, while CNS line calls (3183) have increased, possibly reflecting earlier patient contact and advice-seeking. Actions identified: • Re-audit to assess ongoing impact
Haematology	MED242539	Improving frailty assessments in frail and older persons diagnosed with acute myeloid leukaemia – a quality improvement project	• Implementation of comprehensive geriatric assessments needs to be balanced against service capacity and workflow impact. • The Charlson Comorbidity Index (CCI) and Edmonton Frailty Index are evidence-based, simple tools that can support clinical decision-making in this patient group. • will inform a wider quality improvement project aimed at streamlining frailty assessments. • The goal is to support MDT decision-making and improve treatment planning for frail patients. • Findings highlight the complexity of clinical decision-making in this cohort.
DME	MED242545	QIP – Assessment of compliance to criteria for patients transferred to ward M1	• 66.7% of patients did not originate from DME wards. • 9% of patients were not documented as medically fit or designated for discharge (MOFD). • 65.6% of patients had no documented resuscitation decision at the time of transfer. • 14.8% of patients were transferred without blood results for more than 7 days. • 37% of transfers occurred out of hours, with 9.6% between 9pm and 9am. • 11.9% of patients were discharged within 24 hours of admission to M1. Actions identified: • Review and refine exclusion criteria. • Explore implementation of a pull model from DME wards. • Improve communication with wards regarding the role and limitations of M1. • Link with the team developing treatment escalation plans. • Address factors contributing to delirium, including overnight transfers and early discharge within 24 hours, to reduce length of stay and prevent readmissions.
DME	MED252637	Dysphagia in Parkinson's Disease Patients	• The PD service was well used generally with over 80% of patients showing deterioration being referred to the PD service.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Improvements needed to increase swallow assessments for all PD patients at the front door. • Clinical teams to be more aware to assess and address swallowing concern in PD patients. - completed

Renal	MED242548	Recognition, Investigation, and Management of Hyponatremia in Hospitalised Patients	• Timely recognition of hyponatraemia was strong overall.
			• Key gaps identified in:
			  ○ Comprehensive diagnostic investigation
			  ○ Safe sodium correction practices
			  ○ Documentation, particularly in discharge summaries
			• Improvement opportunities highlighted in volume status assessment, use of diagnostic tools, and structured management approaches.
			Actions identified:
			• Implement EHR-based hyponatraemia investigation order sets
			• Add EHR prompts for standardised sodium management and repeat testing alerts.
			• Introduce a sodium correction flowchart and bedside checklist on wards.
			• Add mandatory discharge documentation tick-box for hyponatraemia in EHR.
			• Monitor documentation and compliance
			• Provide structured education for junior doctors, including mandatory teaching.
			• Deliver targeted teaching, workshops, case-based discussions, and grand rounds presentations.
			• Develop E-learning modules covering aetiology-based management and safe correction limits.
			• Distribute pocket reference cards and display ward posters with management algorithms.
			• Implement a clinical decision aid aligned with European guidelines, included in induction materials and hospital intranet.

Trauma & Orthopaedics	SUR252684	Safe Use and Documentation of Limb Tourniquets in Orthopaedic Surgery: Compliance with BOAST Standards at Arrowe Park Hospital	• Review of 38 operative cases (Oct 2025) assessed pneumatic tourniquet documentation against BOAST standards. • Significant documentation gaps were identified across multiple key safety domains. • Exsanguination was rarely documented (2/38), and the method was largely omitted. • Use of isolation/exclusion drapes was not documented in any case. • Skin checks were documented in only 1 operative note.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Tourniquet pressure and duration were inconsistently recorded, with fewer than 75% of cases including both; only 24% (9/37) were within the ideal pressure range. • Overall compliance with BOAST-required elements was poor and inconsistent. Actions identified: • BOAST guidance posters placed in theatre and anaesthetic areas. • Staff reminders issued regarding essential documentation requirements. • Development of a standardised Cerner smartphrase documentation template to improve consistency and compliance.
Trauma & Orthopaedics	SUR252633	Validating C2AI tool predicting mortality and morbidity in elective hip and knee athroplasty	• Quality improvement project evaluated the accuracy of the C2 Ai (Copeland Clinical AI) tool in elective hip and knee arthroplasty, compared with manual risk tools (SORT, ACS, SURPAS). • An initial retrospective, blinded analysis of 48 patients showed that C2 Ai significantly overestimated mortality compared with established validated tools. • Findings were fed back to the company, leading to adjustments in the underlying predictive model. • A subsequent prospective validation cohort of 39 patients demonstrated a significant reduction in predicted mortality, aligning results more closely with existing risk tools. Further work is recommended, including comparison of predicted versus actual outcomes in a larger cohort and validation across additional surgical specialties.
Trauma & Orthopaedics	SUR252627	Evaluation of suitability of neck of femur fracture patients for digital care management	• The app was originally developed for elective hip and knee arthroplasty and provides: Personalised education, Exercise programmes, Remote monitoring & Communication tools. • A quality improvement survey of 100 surgically managed NOF patients found: - 67% were cognitively suitable for app use - Approximately 54% of suitable patients owned a smartphone - Proposed benefits include improved recovery, fewer complications, and better continuity of care. - Although evidence in trauma populations remains limited, positive outcomes from elective orthopaedic settings and supporting studies (e.g., Crawford et al. 2021) suggest promising potential for adoption in NOF patients.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions

Trauma & Orthopaedics	Sur242575	Audit of post-discharge clip removal arrangements for primary hip and knee arthroplasty patients	• Audit conducted on 100 post-operative patients to assess access to practice nurse appointments for clip removal
			• 45% of patients were unable to secure a practice nurse appointment
			• Patients sought alternative support through:
			  ○ Walk-in Centre: 11%
			  ○ Fracture clinic: 1%
			  ○ District Nurse: 9%
			  ○ Digitally Supported Arthroplasty service: 12%
			  ○ Medically qualified friends: 3%
			• Audit identified differences in processes between sites:
			  ○ Arrowe Park Hospital expects patients to arrange their own appointments
			  ○ Clatterbridge Hospital assists patients with booking appointments
			• Decision made to escalate the issue again with Commissioners

Trauma & Orthopaedics	SUR252636	Monitoring compliance to bone health assessment prior to first orthogeriatric review	• Included patients aged over 65 admitted with fragility fractures (n=28, July 2025) • Timely bone health blood tests were completed in only 43% of patients • Over half of patients did not have required investigations available at orthogeriatric review • When blood results were available, they were always actioned appropriately during review • Three patients received no bone health assessment at all • Delayed or missing blood tests reduced assessment accuracy and highlighted a key gap in care • No clear process identified for DEXA scan referrals Actions identified: • Embedding bone health bloods into ED clerking via POWERPLAN • Reinforcing practice with SHO and senior clinical teams • Improving communication and handover responsibilities between surgical and orthogeriatric teams • Re-audit planned in six months
Trauma & Orthopaedics	SUR252676	Evaluation of Electronic Surgical Checklist System	• Audit of the new E WHO checklist which has been live throughout the trust over the past year. • It audited compliance, and also the opinion of staff using the checklist. • The audit identified excellent compliance, and a couple of issues with the wording of the E

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			checklist, which, having been highlighted, understanding has improved.
General Surgery	SUR242582	Surgical Site Infection in Elective Colorectal Patients	• Surgical site infection (SSI) reduction bundle has improved compliance and helped lower infection rates • Mechanical bowel preparation and oral antibiotics (MOAB) shown to be highly effective Actions identified: • More consistent recording of patient temperature during surgery • Ensure glove changes or use of a sterile closure tray are always documented • Use 2% chlorhexidine with alcohol for skin preparation in all cases unless medically contraindicated. • Business case underway to adopt 2% chlorhexidine as the standard skin preparation • Ongoing data collection aims to reduce SSI rates to 5%
General Surgery	SUR252618	Audit in consent for Emergency General Surgical procedures	• 194 out of 370 consent forms were reviewed • Commonly missing areas included: Alternatives to surgery, risk of non-resolution & Overall documentation completeness • Use of structured consent proformas significantly improved compliance and documentation quality Actions identified: • Targeted consent training • Wider use of standardised consent forms or electronic systems • Departmental initiatives to improve consistency and quality of informed consent in emergency surgery
General Surgery	SUR252631	The unnecessary use of prophylactic antibiotics for management of acute severe pancreatitis	• Audit assessed adherence to local, national, and international guidelines in acute pancreatitis management • Review included 100 cases of acute pancreatitis • 8% of patients required critical care admission • Overall mortality rate was 2% • 12.5% of patients received antibiotics without a clear indication • Inappropriate antibiotic use resulted in four cases of Clostridioides difficile infection • Audit reinforced that pancreatitis is an inflammatory condition rather than an infection Actions identified: • Introduction of ward posters • Departmental teaching sessions • Re-audit planned in four months

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Exploration of an ambulatory pathway for mild pancreatitis cases • Incorporation of HAPS scoring to improve severity assessment

General Surgery	SUR252616	Adherence to post-op anticoagulation guide and prevention of post-op haematoma	• Audit assessed documentation of post-operative VTE management in elective day case hernia repair patients taking anticoagulant or antiplatelet therapy
			• Educational intervention introduced midway through the audit, including:
			  ○ Posters displayed in theatres
			  ○ Discussions with surgeons
			• Documentation standards improved following the intervention
			• Ongoing inconsistencies remained, particularly regarding timing of DOAC restart
			• Across the entire cohort:
			  ○ One patient re-presented with a bleeding complication
			  ○ No serious VTE or bleeding-related events occurred within 28 days
			• Project demonstrated improved awareness among clinicians
			• Findings highlighted the ongoing need for:
			  ○ More consistent documentation
			  ○ Further education
			  ○ Potential future review of local guidelines

General Surgery	SUR252623	Initial blood glucose testing in patients presenting with acute abdomen	• Audit evaluated Trust adherence to national guidelines for investigating surgical patients presenting with acute abdominal pain • Variation identified between SEU and ED in guideline adherence • Full investigation of every abdominal pain presentation recognised as a significant workload burden for both departments In SEU: Routine random blood sugar measurement has been adopted Staff felt performing ECGs for all patients was impractical Certain patient groups were recognised as benefiting from early ECG assessment • Discussion with the ED lead highlighted that ED uses a dedicated “acute abdominal pain bundle” • No equivalent bundle currently exists within SEU, likely due to differences in staffing and working environment Actions identified: • Recommendation made to develop a local flowchart or guideline for assessment and investigation of acute abdominal pain

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Aim is to standardise care across both departments

General Surgery	SUR252639	Audit on documentation of initial radiograph review in emergency general surgical admissions and the following of iRefer guidelines for plain abdominal films	• Baseline audit showed poor compliance, with only 38% of radiographs documented as reviewed
			• Particularly low documentation rates identified for:
			  ○ Chest radiographs
			  ○ Imaging requested in the Emergency Department
			• Findings highlighted unclear ownership and handover responsibility after admission under surgical teams
			• Lack of documented review identified as a potential patient safety and governance risk
			• Concern that undocumented imaging review could contribute to missed or delayed diagnoses
			• Targeted interventions introduced, including:
			  ○ Increased clinician awareness
			  ○ Reinforcement of professional responsibility
			  ○ Proposed clerking prompts to standardise documentation
			• Re-audit demonstrated improvement across all measured parameters
			• Findings supported the effectiveness of simple system-level interventions in improving:
			  ○ Accountability
			  ○ Documentation quality
			  ○ Patient safety within the department

General Surgery	SUR252632	Cholecystostomy drain audit	• Retrospective study evaluated complications and outcomes following percutaneous cholecystostomy drains for calculous cholecystitis • Study included 104 patients • Overall 30-day mortality rate was 5.8% • Complication rates varied depending on the indication for drainage • Unexpectedly higher major complication rates were seen in radiologically simple cholecystitis • Comorbidity burden, measured using the Charlson Comorbidity Index, did not predict major complications • Antibiotic escalation prior to drainage was common and associated with more severe disease • In patients requiring antibiotic escalation, earlier drainage was associated with reduced length of stay • Findings highlighted significant variability in clinical practice

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Study suggests timing and indication for drainage are important factors in optimising outcomes • Supports the development of clearer, evidence-based local guidelines

Head & Neck	SUR252662	Improving Documentation of Patient Information Leaflet (PIL) Provision in Third Molar Surgery Consent Forms	• Cycle 2 showed some improvement in patient information leaflet (PIL) provision
			• Persistent non-compliance was felt to be mainly related to human factors, including:
			  ○ Clinicians forgetting to direct patients to the QR code
			  ○ Failure to document PIL details on consent forms
			Actions identified:
			1. Re-circulate a departmental email emphasising mandatory PIL provision and documentation
			2. Encourage nursing staff to prompt patients to scan the M3M PIL QR code during consultations
			3. Conduct Cycle 3 in November 2025 using the same methodology
			4. Present findings at the departmental audit meeting and identify further interventions

Head & Neck	SUR252663	Audit of Outpatient Oral Surgery Procedure Coding against OPCS-4 Standards in the Oral & Maxillofacial Department, Arrowe Park Hospital	• Retrospective audit assessed accuracy of outpatient oral surgery OPCS-4 coding between July and August
			• 255 procedures were reviewed
			• 88% of procedures were coded
			• Only 29% of coded procedures were accurate
			• Main cause of inaccuracy was use of SNOMED terms instead of OPCS-4 codes
			• Incorrect coding risks include:
			  ○ Loss of income
			  ○ Incomplete activity recording
			  ○ Lack of vetting for outpatient procedures compared with theatre procedures
			Actions identified:
			• Delivered education session including live demonstration and quick reference booklets
			• Further re-audit planned to assess improvement in coding accuracy

Head & Neck	SUR252658	Epistaxis Re-admissions	• 91% of patients did not re-present with epistaxis • 9% of patients re-presented with epistaxis • 60% had anticoagulants documented • 40% had no anticoagulants documented • 40% received first aid advice • 60% received no first aid advice • 100% were prescribed naseptin • No written epistaxis first aid information currently provided to patients

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Actions identified: • Approval obtained to create a simple written first aid information sheet for epistaxis patients • Re-audit planned for April–May to assess whether provision of written advice affects re-presentation rates
Head & Neck	SUR252659	Epistaxis documentation and management// Non - elective ENT admissions	• 50.5% documented presence/absence of oral anticoagulants • 42.5% documented provision of first aid advice • 54.4% prescribed intranasal naseptin or mupirocin at discharge • All prescriptions were for naseptin; both formulary options were cost-equivalent • Identified potential need for a succinct epistaxis proforma in Cerner to improve consistency • Re-audit planned for February–March to assess improvement
Head & Neck	SUR252666	Day Case Tonsillectomy Rates (Paeds)	• Strong “default to day case” culture at Arrowe Park (AP) supporting outpatient management • Most patients live within 45 minutes of AP, making day case surgery feasible • Day case patients use CW beds rather than a dedicated day unit, allowing flexible same-day discharge • Majority of cases are performed on morning lists, supporting efficient discharge planning • Small number of patients are still kept overnight without clear or documented reasons Actions identified: • Develop and circulate a framework based on GIRFT guidance on suitability for tonsillectomy day case surgery • Include criteria for both suitable and unsuitable patients • Plan repeat audit for February/March • Consider impact of winter theatre lists on results • Aim to maintain and improve current 92% day case rate
Gynae	WAC252633	Gynae Assessment Unit - Re-Audit 2025	• 84% of patients requiring doctor review were seen within 4 hours • 22% of all appointments were β-hCG or miscarriage wellbeing calls, reflecting a proactive and holistic service • Triage performance improved from 18.2% to 42% of patients seen within 15 minutes • Only 8% of patients required admission, suggesting effective functioning of GAU and reduced inappropriate admissions

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• 28% of attendances were due to early pregnancy pain or bleeding • All delayed investigations (33%) were ultrasound scans • 20% of first-to-face (FTF) cases seen by GPST/SHO/F1 required senior review or discussion (down from 19% in cycle 1) • Triage within 15 minutes improved to 42%, but remains below the 85% target • Longest waiting times observed after 5pm, possibly linked to reduced senior or SHO availability ("twilight SHO" effect)
Obstetrics & Gynae	WAC252635	Maternal Mental Health Audit	• Excellent compliance when counselling regarding treatment - improved continuity of care - higher proportion of women receiving continuity of care model with fewer women lost to follow-up - Consistent, complete and accurate PMH date capture.
Obstetrics & Gynae	WAC252634	Urogynaecology audit	• Cure rate for colposuspension meeting standard, fascial sling 2.2% away • Standard for need for CISC with colposuspension 1.7% away • Need for catheter after fascial sling
Paediatrics	WAC242536	Is the current template of general paediatric outpatient clinics fit for purpose?	• Paediatric complexity has increased over time, with higher complexity associated with longer clinic duration • Arrowe Park Hospital is currently a regional outlier in allocated time for new paediatric clinic appointments • Clinics are running consistently late under the current template, negatively affecting patient and clinician experience • High DNA (did not attend) rates are present • Audit limitations include a small sample size due to staffing constraints and rotational training availability • Further analysis needed on appointment slot timing versus actual time patients are seen • Average consultant activity per clinic: 7.5 patients seen • Average consultant clinic time spent seeing patients: 230 minutes (3h 50m) • Average consultation time per patient: 32 minutes
Paediatrics	WAC242539	Patient Satisfaction of Outpatient Appointments for Newborn Hearing Screening	• Positive feedback received regarding screening team members • Location and timing of outpatient (OP) clinic were considered satisfactory • Most OP clinic appointment letters were received in good time

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Reminder telephone calls were valued and helped improve attendance • Parents appreciated prompt newborn screening and felt reassured by the process Actions identified: • Use available email addresses to contact parents for appointment information and reminders, alongside existing post and telephone methods • Attach parent information leaflets to email communications • Display Friends and Family QR code for feedback in: o Postnatal Ward 53 o Children's outpatient department

Review of 2025/26

The clinical divisions are responsible for their own audit forward planners with the central Governance Support Unit having oversight and reporting through Patient Safety Quality Board (PSQB). There are dedicated audit days within the divisions whereby completed audits are presented with outcomes and actions needed.

Clinical Audit Priority 1 audits (National) will now be reported to a new Clinical Effectiveness meeting to improve visibility, strengthen assurance, and enhance divisional oversight.

In collaboration with Wirral Community Health and Care NHS Foundation Trust, opportunities for integrated working across the Clinical Governance portfolio have been identified, including strengthening the clinical audit and effectiveness function. This will also involve an introduction of a new streamlined joint wide approach for tracking and logging audits on one system. This will enhance Clinical Audit and Quality Improvement governance processes, with a greater emphasis on demonstrating improvement and sustaining outcomes.

It has also been identified that Trust-wide audit training would be beneficial to support auditors and ensure audit actions are specific, measurable, achievable, realistic, and timely. Arrangements are in place to deliver this training in line with staff roles and responsibilities.

2.2.3 Participation in Clinical Research

Overview of Research Activity 2025/26

The focus this year has been on consolidating the research portfolio and increasing capacity for its delivery.

The Clinical Lead for Research and Research Manager have met regularly with Divisional Leads to promote opportunities and discuss facilitating time for clinicians to be involved in studies. They have continued to liaise with the Wirral Research Collaborative (WRC) and the Commercial Research Delivery Centres (CDRCs) for both primary and secondary care with a view to bringing more commercial activity to the trust.
A more detailed description is given below:

1. **Job Plans**

Two respiratory consultants appointed this year have both been given dedicated time in their job plan for research. They are both acting as Principal Investigators for the non-commercial ASPECT pneumonia and REMAP CAP flu studies. They have also expressed an interest in two commercially sponsored respiratory studies and early discussions are being held locally regarding capacity and capability to conduct these in advance of expressing an interest via the Commercial Research Delivery Network.

2. **Research Team expansion**

The research team has benefitted a great deal from the appointment of three new nurses this year (2.0 WTE). They are working on studies in Critical Care (0.4 WTE), Women and Children (0.6 WTE) and renal, palliative care and respiratory disease (1.0 WTE) and their contribution has had a significant impact on the recruitment rate overall. They have also brought fresh ideas and new enthusiasm to the team, the value of which cannot be underestimated.

3. **Wider expansion of team**

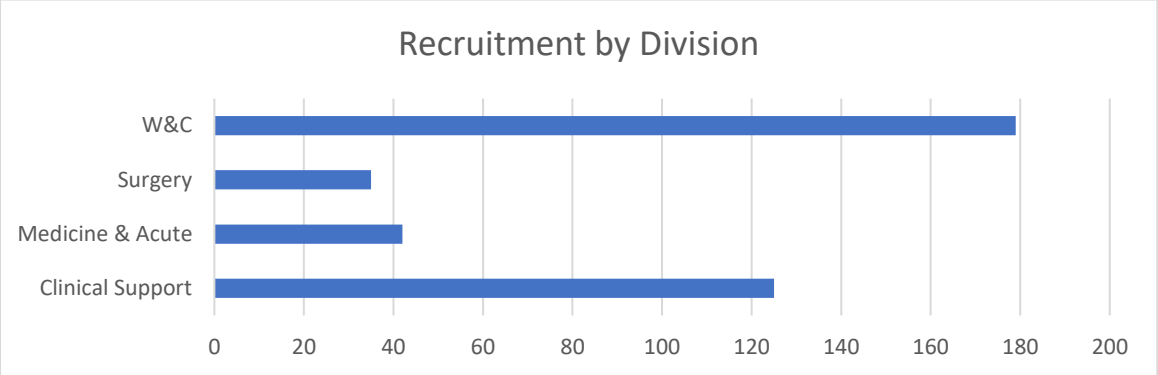
The R&I Manager and Consultant Midwife carried out an exercise with the Divisional Nurses to look at the department's 'readiness' for nurses to be involved in research. This was an initiative from the National Institute of Health Research (NIHR) - SORT – (Self assessment of an Organisation's Readiness for nursing research Tool). The initiative was aimed at Advanced Nurse Practitioners (ANPs) and Consultant Nurses (CN's) who have research included as one of the four pillars in their job descriptions.

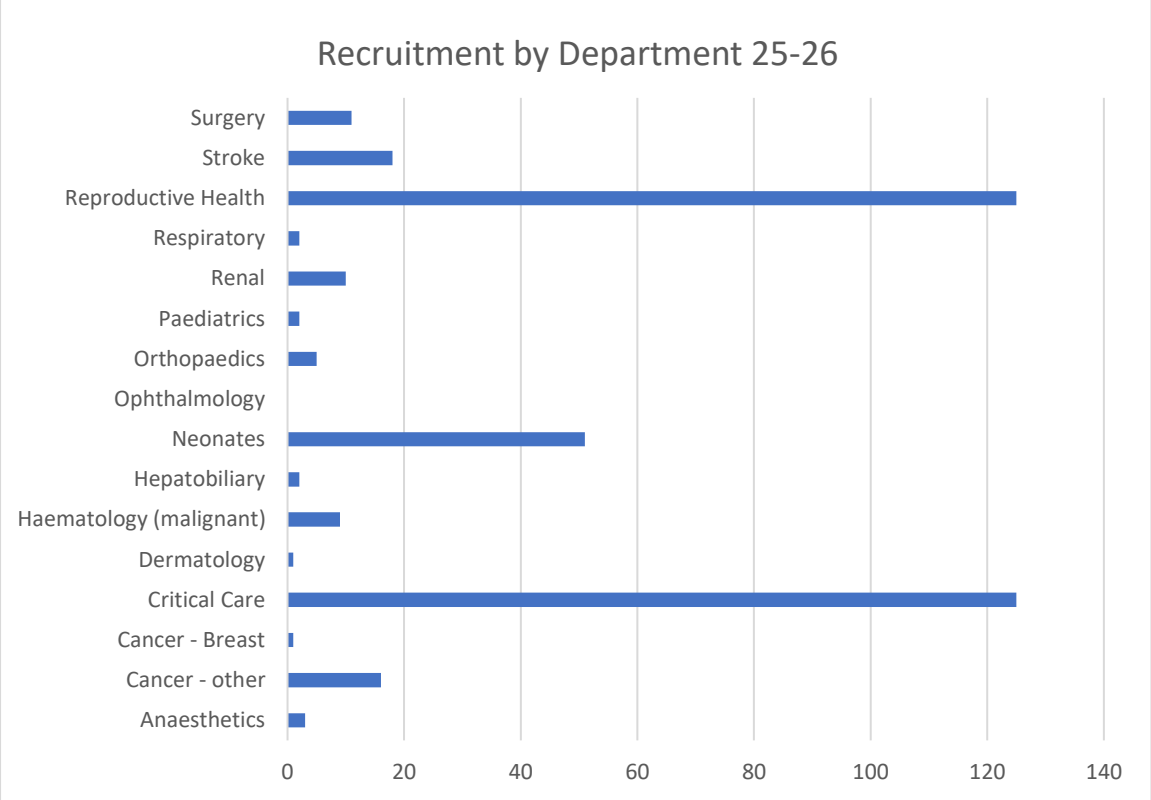
Portfolio development

Whilst the majority of activity remains in Critical Care and Women's and Children Divisions, the portfolio has become more diverse with activity across a number of specialities, including dermatology and palliative care. The trust is also involved in a study of peri operative care of frail orthopaedic patients, led by a consultant anaesthetist, but with involvement from a consultant geriatrician and a number of members of the multi-disciplinary team. This multi-faceted approach gives a much more holistic approach to the care of this patient group and has been welcomed by all involved.
The priority from the NIHR and RRDN is to attract commercial sponsors to place their studies at NHS sites. There are two commercial studies in renal disease and dermatology which are about to open and will be conducted at the R&I centre at the Clatterbridge site, with two more currently in set up.

WUTH has good relations with the CDRCs for both primary and secondary care and this offers great potential to extend the commercial portfolio further in the future, especially with the imminent completion of the merger with Wirral Community Trust.

The following graphs show recruitment activity by division and department at the time of report.





2.2.4 Commissioning for Quality and Innovations (CQUIN) Indicators

There was no CQUIN reporting in 2025/26.

2.2.5 Registration with the Care Quality Commission (CQC)

The Trust is registered with the Care Quality Commission without conditions.

During May 2025, the Trust's Urgent and Emergency Care Services and Medical Care Services (including older people's care) were inspected by the CQC. Whilst both service inspections resulted in an overall rating of 'Requires Improvement' a strong foundation of areas rated as 'Good' was identified throughout the inspection process, demonstrating the Trust's commitment to continuous quality improvement.

Medical Care Services were rated at 'Good' in the Effective, Caring and Well-led domains; with inspectors noting the following good practice:

- Staff worked together as a team to benefit patients and proved safe care and followed policies and guidelines to plan and deliver care
- The service had relevant information promoting health lifestyles and support on the wards and units
- Staff listened to and understood people's needs, views and wishes, responding to people's needs in the moment and acted to minimise any discomfort, concern or distress
- The caring nature of staff supporting other staff member's strengths, abilities, aspiration, culture and protected characteristics was also highlighted by inspectors
- The service was recognised for caring about any promoting the wellbeing of staff and supporting them to always deliver person-centred care
- Staff and leaders had a shared commitment to improving services for patient and their families
- The service demonstrated a good standard of care, had a shared direction and culture with inclusive leaders at all levels who embodied the culture and values of the organisation
- Leaders let effectively with integrity, openness and honesty

Urgent and Emergency Care was rated as 'Good' in the Effective domain, with inspectors noting:

- Staff ensured people's care and treatment was effective by assessing and reviewing their health, care, wellbeing and communication needs with them
- Mental health risks were well managed
- The safeguarding team was approachable, and staff were aware of how to seek support from the designated safeguarding nurse
- The service implemented reasonable adjustments as appropriate, for example providing care bags for autistic people and people with disabilities

A comprehensive action plan was developed following the service inspections, monitored at Divisional Quality Board reporting by exception to the Trust's Patient Safety Quality Board.

The service inspections did not change the overall CQC rating of the Trust, which remains 'Requires Improvement' following the last comprehensive inspection of the Trust in 2019/20. During this inspection improvements were noted in the well-led and safe domains.

2.2.6 External Accreditations

The Trust has gained national accreditation for the quality of services provided in many wards and teams.

Current Clinical external accreditation:

Accreditation	Area
JAG Accredited	**Endoscopy**
UKAS A world of confidence	**Blood Sciences – Planned surveillance inspection occurred in November/December 2025, awaiting outcome regarding maintenance of accreditation.** **Microbiology – Planned surveillance inspection occurred in August 2025, awaiting outcome regarding maintenance of accreditation.** **Histopathology**
BSGE	**Women and Children's** **Endometriosis Centre for 2025**
Special Interest (SPIN) module application guidance	**Formal SPIN approval for Mersey and Wales trainees within Neonatal placements**

2.2.7 Freedom to Speak Up

WUTH developed the role of Freedom to Speak up (FTSU) Guardians in 2015, prior to National guidance being issued by Sir Robert Francis. A multiple Guardian approach was implemented, with a designated Lead Guardian identified. Since then, we have been significantly involved in shaping national policy and guidance around this agenda and working hard to improve the Trust's speaking up culture.

The Trust has been keen to continue support for the overall FTSU service and identified ringfenced time for the Lead Guardian role.

The Guardian is supported by a network of 40 trained FTSU Champions, whose role is to work within their service areas, promoting and encouraging staff to speak up and signposting to the FTSU Guardian.

Where a member of staff does not feel able to speak up through the normal management channels, they are encouraged to contact the 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. Guardian walkabouts take place across the Trust 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 1 received in 2025/26, which is a positive indication that staff continue to feel confident in approaching the FTSU Guardian or their local management teams.

The FTSU Guardian maintains confidential records relating to information spoken up about and can 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 as required. Progress is fed back to the reporter along with any outcomes or actions taken. The FTSU Guardian monitors actions and outcomes and will escalate circumstances if concerns remain unresolved.

Our 2025/26 data shows a reduction in a number of people accessing the FTSU service, however those that are, are accessing the FTSU service across all Divisions and a range of occupational groups.

Numbers of staff speaking up regarding patient safety has increased and falls in line with national data.

Incident reporting processes continue to capture patient safety concerns and further promotion of the FTSU service and enhanced engagement with clinical staff will be undertaken for 2026/27.

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 continues to operate a joint working protocol between the FTSU Guardian and the Counter Fraud Specialists. This is an understanding that any concerns raised that concern fraud the fraud specialists will be notified.

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 WUTH staff networks. A number of staff network members (including LGBTQ+, Multicultural, staff with disabilities and long-term conditions, the menopause network and 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 takes place for speaking up data. 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 because of speaking up and data is submitted to the National Guardians Office as required for further monitoring.

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

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

2.2.8 Information on Secondary Uses Service for Inclusion in Hospital Episode Statistics

WUTH submitted recordings during 2025/26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of record in the published data which included the patient's valid NHS number was:

Admitted Patient Care	Outpatient Care	Emergency care
99.9%	100%	99.7%

The percentage of records in the published data which included the patient's General Medical Practice (GP) Code was:

Admitted Patient Care	Outpatient Care	Emergency care
99.9%	97.8%	98.7%

2.2.9 Information Governance

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

The Trust will undertake Phases 1 and 2 of the required external annual audit of the Data Security and Protection Toolkit (DSPT) ahead of the final submission. Last year's audit was conducted on 12 outcomes and the Trust successfully met the achievement levels for 9 of these and implemented an action plan for the other 3 outcomes. The audit recognised low deviation between the independent assessment and the self-assessment for all 12 outcomes, resulting in a 'High Confidence' level being achieved for the veracity.

The main focus for the year has been to review and improve the Trust's Information Rights processes and use new technology to increase the resilience and stabilise the services. The recent changes to the DSPT (which is now based on the Cyber Assessment Framework) have continued to be embedded this year and we have continued to build on the work completed for last year's submission.

We continue to support and enable the latest processes, technologies and clinical developments by risk assessing the use of Personal Data via Data Protection Impact Assessments. This ensures that the Personal Data of patients and staff is processed in a legal, secure and transparent way to support safe and efficient healthcare provision.

Four data breaches have been reported to the Information Commissioner's Office (ICO) by the Trust to date (see tables below) as they all met the threshold for reporting.

Reported by WUTH

ICO Number	Date	Incident Details	Status
IC-391161-R1J9	Jun-25	A sensitive referral document printed on the incorrect printer.	ICO closed.
DSPT 45729 (165908) IC-460275-K1K0	Dec-25	A patient was messaged by someone she knew regarding her medical treatment.	Open - Awaiting response from ICO.
IC-471126-C4R4	Jan-26	Discharge information for a patient was sent to the incorrect pharmacy.	ICO closed.

Reported by Data Subject

ICO Number	Date	Incident Details	Status
IC-342023-X9P6	Apr-25	Patient contacted the ICO about a previous formal complaint. ICO asked the Trust to contact the patient and a further formal response was sent to the patient.	No further contact from the ICO.

2.2.10 Clinical Coding

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

In 2025/26 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 moderate assurance.

The first of these was an audit of 110 episodes discharged under Cardiology, Geriatric Medicine and Stroke specialities performed in July 2025. The overall accuracy of our coded data was reported as:

Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
86.36%	92.91%	97.83%	95.83%

A second audit of 100 episodes discharged under Paediatrics, Urology and ENT specialities was performed in September 2025. The overall accuracy of our coded data was reported as:

Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
86.00%	82.52%	87.14%	52.57%

These external audits were supplemented with additional internal audits throughout the year focusing primarily on the accuracy of individual coders. The Trust have two Approved Clinical Coding Auditors in post.

The Trust will be taking the following actions in 2026/27 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.
- Exploring the use of digital solutions to support the clinical coding process.

We continue to support staff development; this year one member staff passed the National Clinical Coding Qualification becoming Accredited Clinical Coders. Two staff maintained their Approved Auditor status

2.2.11 Learning from Deaths

During 2025/26, 1,755 of Wirral University Teaching University patients died during an inpatient episode of care. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
431	411	443	470

The Medical Examiners (ME) continue to maintain independent scrutiny of all mortalities within the Trust and escalate cases where potential concerns are identified, which are then reviewed by the Mortality Review Group (MRG), held fortnightly, and consideration given as to whether any additional type of review or investigation would be appropriate.

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. Mortality reviews are also undertaken for all deaths where the patient has a learning disability, autism or a history of serious mental health disorder. Further Quality Assurance mortality reviews are performed on a random sample (approximately 3% of all deaths). Those reports are shared at the MRG, and any concerns are highlighted and considered for further review.

During 2025/26 a total of 226 mortality reviews received further review. This consisted of 66 Escalated Mortality Reviews, 137 Quality Assurance PMRs and 23 Learning Disability Reviews.

We continue to report all deaths of people who are service users with an established diagnosis of learning disability to NHS England's LeDeR Programme (Learning from lives and deaths – People with a learning disability and autistic people). Wirral University Teaching Hospital reported 24 deaths to LeDeR between 1st April 2025 and 31st March 2026. 21 of these deaths occurred in hospital, a further

3 were additionally notified as we were made aware of their deaths in the community and had not been reported to LeDeR by any other sources. Of the 24, 20 had a LD diagnosis, 1 autism only and 3 had both.

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

Quarter 1	Quarter 2	Quarter 3	Quarter 4
43	55	58	70

Learning identified through review of mortality reviews

Learning for mortality is derived from 3 main sources.

- Mortality reviews (collated into a learning log)
- Themes and trends escalated from the Medical Examiner
- Learning identified through the PSIRF process.

Specific learning and themes identified as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
DNACPR forms are not always fully completed or not done when it would be appropriate to do so.	Mortality reviews	Learning is fed back on an individual basis in real time. From April 2025 the Trust will be participating in the national cardiac arrest audit (NCAA) that will help identify learning Learning fed back to resuscitation officers
Medication errors	Mortality reviews	All medication errors are fed back to relevant clinician. If a medication error has resulted in possible harm this is picked up under the PSIRF process. Themes and trends are discussed at MSOP and feedback to all clinical areas
Missed opportunity to prescribe aspirin	PMRT	Aspirin protocol reviewed to ensure high risk patients are not missed
Nosocomial Infections prolonging length of stay	Mortality reviews	SOP for side room allocation reviewed. Proactive HPV cleaning programme initiated for C Diff cleans
Poor documentation/ copying and pasting of medical documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads. The EPR template has been adjusted to remind staff not to copy and paste notes as routine.
Poor thermoregulation during 1st day of life	PMRT	New process in place to reflect national guidance

Lack of Nutrition, particularly in complex patients	Mortality reviews	Reviews escalated to Nutrition subgroup and AMD for safety and quality for shared learning. Feedback to teams. Education around ensuring escalation of nutrition concerns early

Mortality Review Group (MRG) is notified of all new Coroner's inquests where the Trust is an interested party. Any issues in care identified through reports obtained for the Coroner are highlighted to the MRG and senior managers in Quality Governance for consideration as to whether any additional review/investigation is required. Learning arising from concluded inquests is shared with senior managers in Quality Governance and clinical leads meetings.

2.3 Reporting against Core Indicators

2.3.1 Summary Hospital Level Mortality Indicator (SHMI) value and Banding

The SHMI is the ratio between the actual number of patients who die following hospitalisation at WUTH and the number expected to die on the basis of average England figures taking into account the patient cohort and acuity of WUTH. SHMI gives an indication for each non-specialist acute NHS Trust in England whether the observed number of deaths with 30 days of discharge from hospital was 'higher than expected' following the below banding compared to the national baseline.

SHMI Band	Band Meaning
1	Higher than expected
2	As expected
3	Lower than expected

The last year's most up to date data (published 8th January 2026) is in the table below. Due to time lapses in the data processing there is a 4-5 month deficit.

Reporting Period	SHMI Value	Banding
JAN22 – DEC22	1.06	2
FEB22 – JAN23	1.05	2
MAR22-FEB23	1.04	2
APR22 – MAR23	1.06	2
MAY22-APR23	1.06	2
JUN22-MAY23	1.06	2
JULY22 – JUN23	1.07	2
AUG22-JUL23	1.07	2
SEP22-AUG23	1.06	2
OCT22-SEP23	1.07	2
NOV22-OCT23	1.07	2
DEC22-NOV23	1.07	2
SEP23-AUG24	0.98	2
SEP24-AUG25	1.04	2

2.3.2 WUTH Patient Reported Outcome Measures (PROMS) – Hip and Knee Replacement Procedures

The Patient Reported Outcome Measures (PROMs) for hip and knee replacement for 2024/25 were recently released on 2 April 2026.

There is a built-in delay in the reporting period for these patients, as the post-operative assessment occurs approximately 6 to 9 months after the operation to allow for full recovery. The results are therefore analysed by NHS Digital and released approximately 12 months after the procedure.

The Trauma and Orthopaedic Directorate has been fully engaged with the national Patient-Reported Outcome Measures (PROMs) study over the past few years.

The criterion for analysis is that the patient completes the Q1 documentation within 30 days of the operation and then completes the Q2 (sent independently by post via NHS Digital) approximately 6 months post-procedure.

We have now ensured that nearly all patients complete the Q1 form at the pre-operative Joint School and are informed of the importance of completing the Q2 form upon receipt, approximately 6 months post-procedure.

Nationally, there has always been a significant drop-off in Q2 form completion, and 30 completions are required for units to be included in the analysis. As a result, several units have not been included in this year's analysis. However, WUTH has had 128 knee replacement returns and 143 hip replacement returns, enabling a full analysis.

Three metrics are reported for the procedures –

Two generic health markers (EQ-VAS and EQ-5D) and one joint-specific validated measure (Oxford Hip Score/Oxford Knee Score).

Total Hip Replacement Results –

The hip replacement data indicate that patients treated at WUTH achieve the expected health gain across all three metrics. Approximately 77% report an improvement in the EQ-VAS, 89% report an increase in the EQ-5D, and 99% report an improvement in the Oxford Hip Score.

The magnitude of the improvements in the groups is modelled by NHS Digital, and the results show satisfactory performance across all 3 metrics in the hip group.

Figure 1 - Total Hip Replacement EQ-VAS Results – Above average health gain

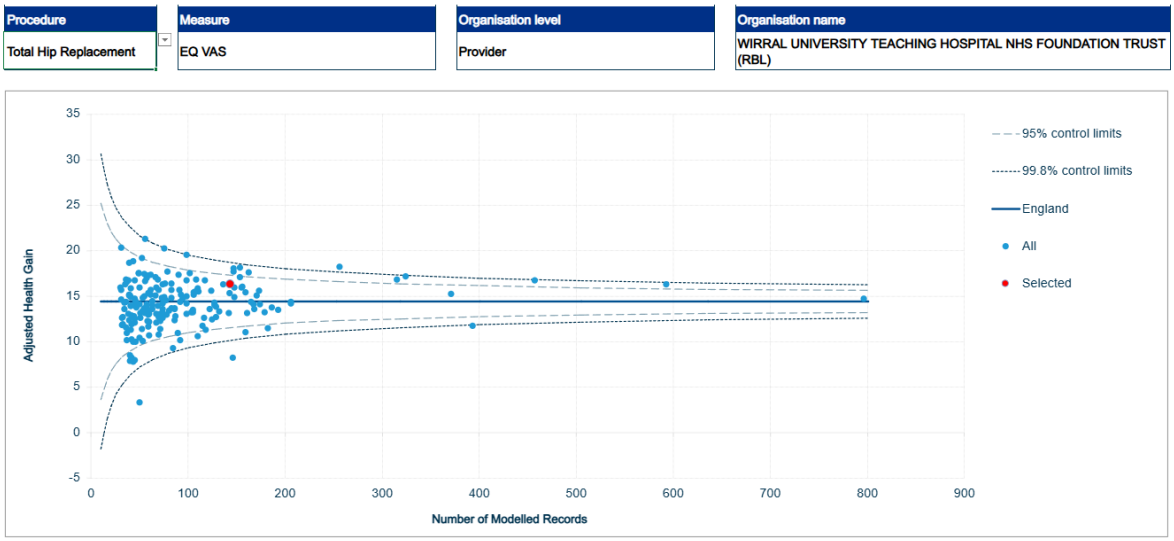


Figure 2 – Total Hip replacement EQ-5D Results – Slightly below average health gain but well within normal distribution

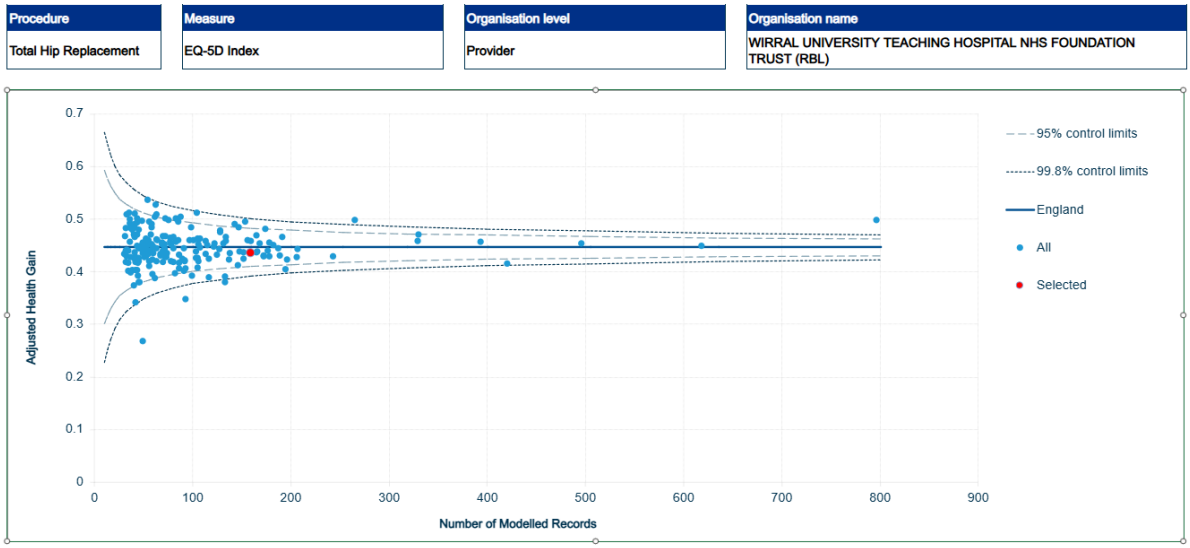
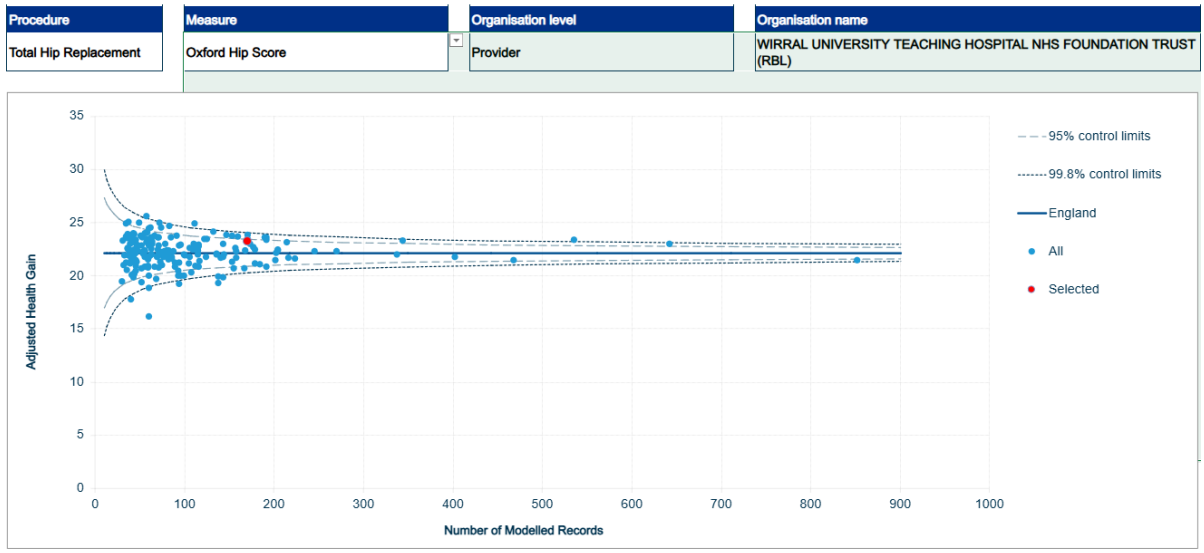


Figure 3 – Total Hip Replacement Oxford Hip Score Results – Above average health gain



Knee Replacement Results –

The knee replacement data indicate that patients treated at WUTH achieve the expected health gains across all three metrics. Approximately 71% report an improvement in the EQ-VAS, 80% in the EQ-5D, and 95% in the Oxford Knee Score.

The magnitude of the improvements in the knee replacement group has been modelled by NHS Digital, and the results indicate satisfactory performance on the EQ-VAS and EQ-5D, with positive outlier improvement on the Oxford Knee Scores (top 5%).

Figure 4 – Primary Knee Replacement EQ-VAS Results – Above average health gain

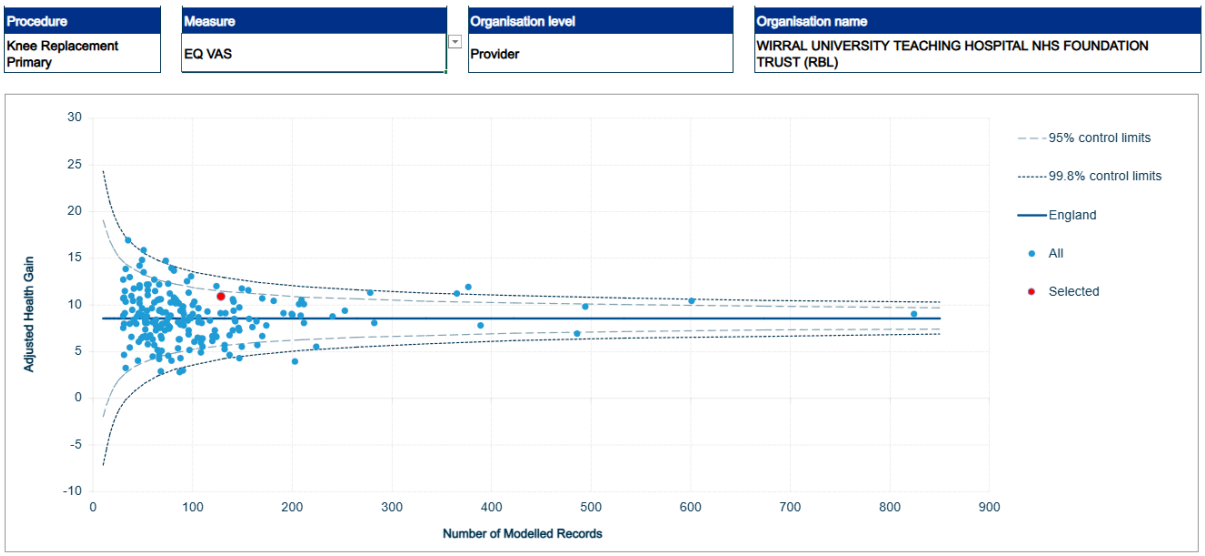


Figure 5 - Primary Knee replacement EQ-5D Results – Above average health gain

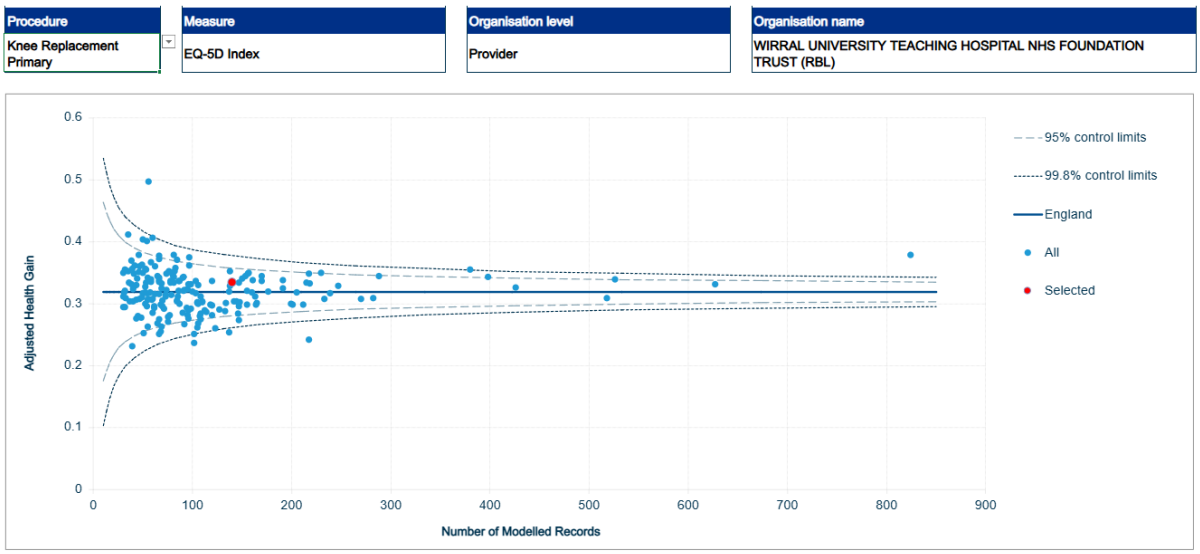
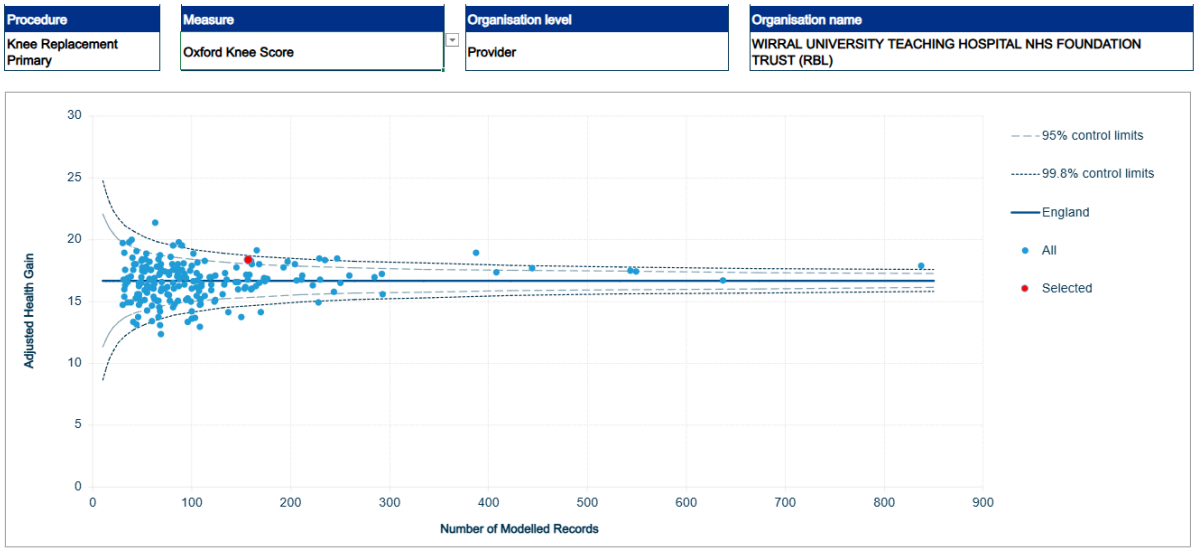


Figure 6 – Primary Knee Replacement Oxford Knee Score Results – Positive outlier result (top 5%)



Summary

The report highlights the Directorate's work to ensure a high-quality hip and knee arthroplasty pathway. This includes patient selection, aligning patient expectations, prehabilitation via the MyMobility App, standardised inpatient care, and digitally supported rehabilitation. The results indicate that this approach is progressing satisfactorily.

2.3.3 The Percentage of Patients Readmitted to Hospital Within 30 Days

The occurrence of emergency readmission to the hospital shortly after a previous discharge can serve as an indication of the quality of care provided by an organisation. It is important to note that not all emergency readmissions are part of the original planned treatment, and some of them may be potentially avoidable. By reducing the number of avoidable readmissions, the overall patient experience of care can be improved, and hospital beds can be made available for new admissions. However, it is crucial to conduct a detailed analysis to determine whether a readmission was avoidable, as the reasons behind it can be highly complex. For instance, in certain chronic conditions, the patient's care plan may involve monitoring the deterioration of their condition and anticipating the need for hospital care. In such cases, a readmission may actually indicate a higher quality of care.

Readmission rates are calculated nationally by NHS England and giving a banding.

2.3.4 Ensuring People have a Positive Experience of Care

WUTH is committed to ensuring that its patients and service users have a positive experience. The Friends and Family test FFT is a primary source of patient experience monitoring data used within the NHS. WUTH has a localised target of achieving a recommend rate of ≥95%, Maternity services have achieved this Mar 25 – Jan 26. Adult inpatients achieved a ≥93%. Direct comparison with other NHS organisations demonstrates that WUTH's FFT performance for services including, Emergency Department (ED) and Outpatients are in line with national

and peer averages. WUTH receives approximately > 30,000 FFT responses a year.

During 2025/26 the CQC have published 3 patient experience national surveys. CQC banded WUTH as "Better" than other organisations for 6 indicators within the Children & Young People, no indicators were banded as "Worse". In addition, WUTH were in the top performing regional organisations for 5 of the 18 scored sections. CQC also banded WUTH as "Better" than other organisations for 4 indicators within the National Maternity Services survey, no indicators were banded as "Worse". WUTH were highlighted as being in the top 5 regional trusts for Maternity Services for 5 out of 9 sections including being the highest scoring Trust for assessment and evaluation. WUTH has a strong working partnership with Wirral Maternity & Neonatal Voices Partnership and continues to work closely to support the needs of the community in this area.

The 3rd CQC survey publication was for Adult Inpatients which had similar results with 4 indicators banded as "Better" however 1

indicator was banded as worse in relation to lighting impacting patients' ability to sleep. This has been included within an action plan

All results are available for review Surveys - Care Quality Commission

The NHS Staff survey is conducted annually. The Trust had 42% of staff that responded and although this was down from the previous year, 2825 people shared their views on what it's like to work here.

Indicator from 'We are Compassionate and Inclusive'	2024/25	2025/26	Benchmark
I feel my role makes a difference to patient/service users	86.90	87.09	Below national average
Care of patients / service users is my organisation's top priority.	65.00	59.08	Below national average
My organisation acts on concerns raised by patients / service users.	62.96	59.16	Below national average
I would recommend my Organisation as a place to work	52.86	46.89	Below national average
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	58.15	52.74	Below national average

Wirral University Teaching Hospital is below the national average in the above 5 indicators.

In response to the 2025 staff survey results there will be a number of actions, including:

- Understanding and sharing the results at key managerial meetings and with staff side
- Sharing local results in the divisions and directorates to develop local actions
- Focussing on Trust-wide actions to support improvements in staff experience

The Quarterly Pulse Survey results will continue to be shared through local groups including management meetings.

We will provide assurance of our progress through the actions identified reporting into the People Committee.

2.3.5 Venous Thromboembolism (VTE)

Venous thromboembolism (VTE) is defined as a blood clot that forms in a vein which partially or completely obstructs blood flow. This includes deep-vein thrombosis (DVT) and pulmonary embolism (PE).

The Incidence of VTE in the UK is 1 in every 1000 people each year. This can be associated with significant morbidity and mortality. Importantly, hospital admission is a significant key risk factor which can increase your likelihood of VTE.

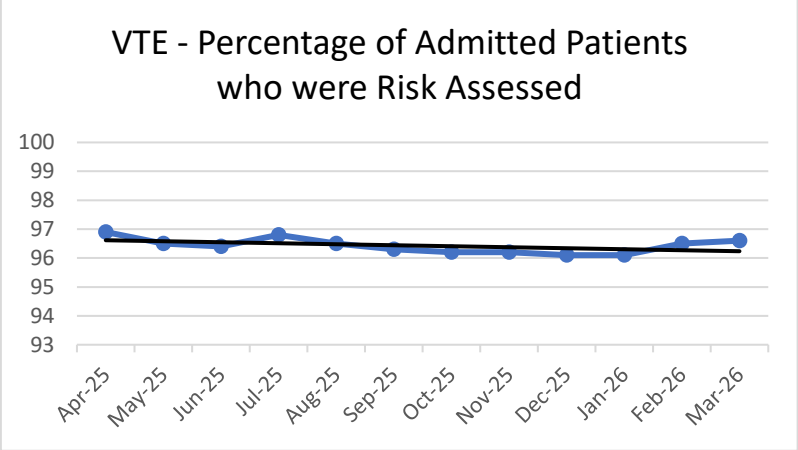
Hospital-acquired venous thromboembolism (HAT) is defined as a VTE which occurs within 90 days of a hospital admission. 50-60% of all VTE are hospital acquired.

The trust's VTE policy (POL 199 VTE (Venous Thromboembolism in Adults (The Prevention Management of)) states that:

- Initial VTE assessment should be completed with 12 hours of admission,
- Consultant VTE assessment should be completed within 27 hours of admission.
- VTE assessment should be reassessed with a change in clinical condition.

This policy is based on the recommendations made by NICE in March 2018. (NICE Guideline NG89: Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism).

Presented in the graph below is the percentage of patients who were admitted to hospital and who were risk assessed for VTE:



The table below shows VTE assessment compliance from April 2025 – March 2026 by division, including initial assessments and consultant-led VTE assessments. The Trust aims to reach a standard of 95% of patients have an initial assessment (or consultants' assessment if this is first assessment completed) within 12 hours of admission.

	VTE assessment completed during admission	Initial VTE assessment with 12 hours of admission
Medicine	**95.9%**	**90.6%**
Surgery	**98.6%**	**97.2%**
W&C	**92.9%**	**91.1%**
Total	**96.4%**	**92.7%**

This data is collated electronically and can be accessed via the Trust's Business Intelligence portal. Significant work to help improve the accuracy of this data has been conducted and is regularly monitored by the Trust's VTE Steering group.

2.3.6 *Clostridioides difficile* Infections

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) continues to support the prevention of Healthcare Associated Infections (HCAIs) and reinforce the commitment to keeping patients, visitors, and staff safe. Assurance of quality and safety in relation to infection prevention and control (IPC) is delegated from the Patient Safety Quality Board (PSQB) to the monthly IPC group and can be evidenced through the IPC Board Assurance Framework (IPC BAF).

Challenges in the management of infections have continued to be experienced nationally with the Trust experiencing the same challenges in all Healthcare Associated Infections (HCAIs), particularly CDI.

A rapid evaluation of care (REC) is conducted for all patients diagnosed with a healthcare associated CDI to determine themes and trends, and to extract learning which can be used to prevent further cases. Every case is scrutinised by both the nursing and IPC teams and common themes remain similar to previous years which include antibiotic usage, timely obtaining of samples and isolation. This year we have continued to see a theme around recurrence of infection and / or re-infection. WUTH offer Faecal microbiota transplantation (FMT) to patients who have recurrent CDI.

Effective infection prevention and control practices will remain a key focus for the Trust in 2026/27, by ensuring that we adopt a systems-based approach to our learning responses will provide more insight into the systems and processes that we need to improve to reduce CDI.

Following the completion of RECs, the IPC team have identified areas of practice and infrastructure which can be improved, these will form part of a refreshed organisational quality improvement

approach to improving and sustaining a reduction in cases going forwards. WUTH intends to take the following actions to improve this position for 2026/27:

- Reset, revisit and refresh the IPC programme
- Fully align the management of IPC incidents to PSIRF
- Develop a comprehensive trust wide action plan, using learning from RECs, to determine the quality improvements needed to improve our approach to HCAIs, this will include:
    - Identification of a dedicated decant facility
    - Review of current cleaning and disinfection processes
    - Isolation pathway
    - Antimicrobial prescribing
    - Sampling processes
    - Side room suitability including provision of en-suite accommodation
- As part of wider IPC improvements, launch a sustained bare below the elbow / back to basics campaign
- Implement recommendations from national working group which has been established by UKHSA to further understand the challenges and national increase in cases

2.3.7 Patient Safety Incidents

Wirral University Teaching Hospital is committed to and promotes reporting and investigating adverse events and near misses, as it is recognised that this provides the Trust with opportunities to learn, improve the quality of services and reduce the risk of those types of events happening again. The process for the management of reported incidents is described within the Trust's Incident Reporting Policy and Procedures.

The Trust fully transitioned across to Learning from Patient Safety Events (LFSPE) In September 2023 this is now the first full year that we have been reporting into LFPSE. This now allows organisations to assess its incident data by physical and psychological harm to each patient, rather than just a previous level of harm for the incident. Work is currently ongoing with NHSE who are creating national data Dashboards to be able to report from.

Degree of Harm in Incident Reports

The following categories are used across the NHS for patient safety incident reports:

No Harm – a situation where no harm occurred: either a prevented patient safety incident or a no harm incident.

Minor Harm – any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons.

Moderate Harm – any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons.

Major Harm – any unexpected or unintended incident that caused permanent or long-term harm to one or more persons.

Catastrophic, Death – any unexpected or unintended event that caused the death of one or more persons. WUTH also uses these categories for non-patient safety incidents.

These are also used for incidents that do not relate to harm to a service user: for example, physical assaults and violence against staff, information governance and security incidents.

The data below is the latest published date for 2025/26. In this reporting period the Trust only reporting into the LFPSE. This data has been validated by the LFPSE and each patient safety incident is reviewed for accuracy during its clinical managerial review.

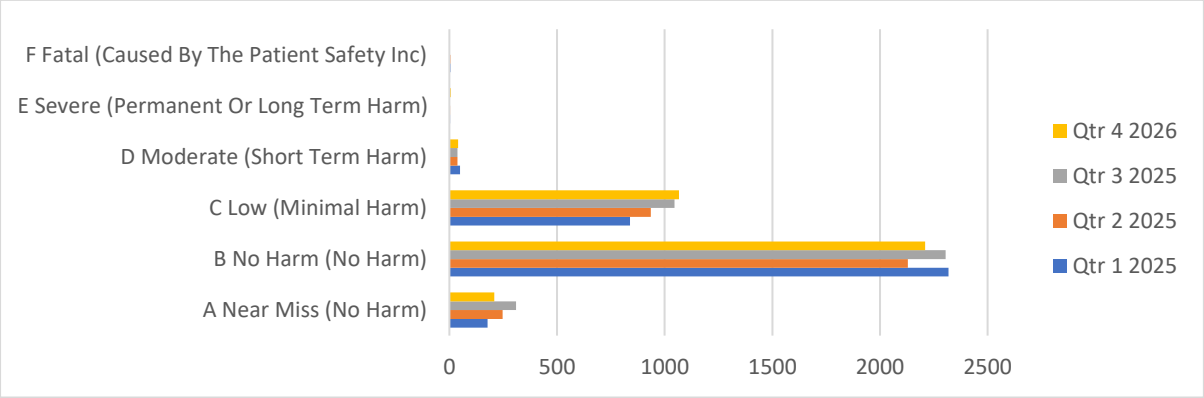
	2025-26 Qtr 1	2025-26 Qtr 2	2025-26 Qtr 3	2025-26 Qtr 4	Grand Total	Percentage
Near Miss (No Harm)	178	247	310	209	944	5.85%
No Harm (No Harm)	2319	2130	2305	2210	8964	55.53%
Low (Minimal Harm)	839	936	1046	1066	3887	24.08%
Moderate (Short Term Harm)	49	38	37	41	165	1.02%
Severe (Permanent or Long Term Harm)	4	4	2	6	16	0.10%
Fatal (Caused by The Patient Safety Inc)	5	5	1	0	11	0.07%

From 1st April 2025 – March 31st, 2026, there was a total of 16143 incident reported to LFPSE. Currently there are 2156 incidents which have not had a level of harm recorded against them yet.

Under the Patient Safety Incident Response Framework (PSIRF) there were 7 Patient Safety Incident Investigations (PSII) initiated, during this period the Trust reported 4 Never Events.

The trust has embedded PSIRF and has really focused on the learning, over the last year everything we have learned from doing PSIRF investigations we have decided to relaunch the way in which we investigate and report, with plans going into 26/27 financial year to improve on how we currently

undertake PSIRF. An audit of PSIRF in the Trust was conducted by MIAA, which provided substantial assurance.



Part 3

3.1 Overview of the Quality of Care and Performance

We describe within the following section, additional improvement activities that we have undertaken within year.

3.1.1 Staff survey

The NHS Staff Survey, undertaken by independent external organisation, Picker Europe, took place between 29 September and 28 November 2024. The Trust applied a mixed mode of paper based and electronic (via email) surveys in order to maximise access and completion of survey, with an increased number of paper copies made available this year, for our Estates and Facilities teams and for areas that were identified by Divisions as may benefit from a paper version.

We had a 42% response rate this year, with 2,825 staff completing the survey. This is just below the Acute and Acute & Community sector average of 47%, and lower than last year at 47%.

Survey results continue to be categorised against the national NHS People Promise with feedback measured across the seven elements. It also measures two elements of the survey separately as it has in previous years, Engagement & Morale. This is also congruent with the Trusts Workforce Strategy which acknowledges the requirements of the national People Promise.

Overview of People Promise theme results and comparisons to sector average:

People Promise Elements	Trust 2025 Score	National 2025 Comparator Average	Statistically significant Change from 2024?
We are compassionate and inclusive	7.15	7.28	No
We are recognised and rewarded	5.61	5.87	No
We each have a voice that counts	6.33	6.60	Yes
We are safe and healthy	5.83	6.07	Yes

We are always learning	5.22	5.57	Yes
We work flexibly	5.99	6.22	No
We are a team	6.55	6.75	No

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'.

Theme	Trust 2025 Score	National 2025 Comparator Average	Statistically significant Change from 2024?
Engagement	6.35	6.74	Yes
Morale	5.48	5.84	Yes

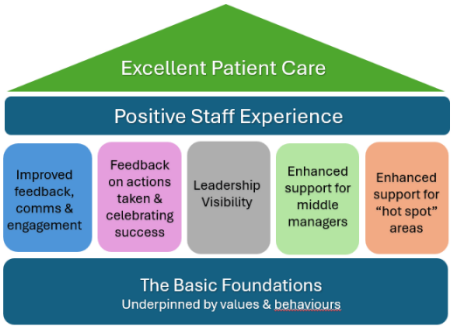
Positive feedback was highlighted:

- More staff feel that their role makes a difference to patients and service users this year.
- Less staff have experienced bullying and harassment from colleagues or managers.
- Less staff are experiencing discrimination from patients, managers and colleagues.
- Less staff are experiencing physical violence from patients and colleagues and of those that do, more staff are reporting it.
- Staff are more satisfied with teamworking, with improvements in colleagues being understanding and kind; feeling respected, showing appreciation and staff feeling valued by their team.
- More staff feel that reasonable adjustments are being made to support them at work.

Areas for improvement are:

- More staff are reporting they do not have adequate materials, supplies and equipment to do their job.
- Staff are less satisfied with flexible working and achieving a balance between home and work.
- More staff are feeling burnt out and frustrated by work and are less satisfied with positive action taken by the organisation on health and wellbeing.
- Whilst staff feel more encouraged to report errors, near misses and incidents, staff are less confident that action will be taken as a result of reporting, with lower levels of feedback received.
- Staff are less satisfied with support to develop their potential; with less access to clinical supervision, learning and development opportunities.

1. On review of survey findings, the following areas of focus are proposed for 2026/7



- Improved feedback, communications and engagement
- Feedback on actions taken and celebrating success
- Leadership visibility
- Enhanced support for middle managers
- Enhanced support for 'hot spot' areas

The 2025 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 2025/26 Trust wide plans including People Strategy delivery plan. Further to this, survey results will also inform 2025/26 divisional delivery plans.

Workshops have been undertaken to share findings, support understanding of data and to identify focus areas and inform plans for 2026/27 for Divisions, Corporate Service Heads of Service, subject matter experts and key enabling strategy leads.

A programme of cascade is being implemented throughout March and April, with Divisional events scheduled to feedback results to staff and provide an engagement opportunity to work together with staff on identifying key areas of priority and actions needed to support improvements. Additional workshops are also being implemented to focus on key areas including speaking up / raising concerns and to understand experiences of staff who share protected characteristics.

3.1.2 Occupational Health & Workforce Wellbeing

We are committed to supporting the health and wellbeing of our staff and as such have developed our Health and Wellbeing Programme throughout the year. We have introduced a number of measures to offer enhanced support, boost morale, support mental and physical wellbeing and to help build resilience.

Improvements and key activities achieved this year includes:

- Implement phase one of the new Cority IT system
- Improved Occupational Health referral to treatment times and health report turnaround times.
- Increased psychotherapy capacity has been established to support staff.
- Responsive psychotherapy for staff in reaction to event inside and outside of the Trust
- Listening events within Women and children's division
- Mental health first aid training continue and support events organised for trained staff
- MIAA audit into wellbeing gave substantial assurance with 3 actions regarding comms and one policy update
- A range of social networking opportunities now available, including our disability, multicultural and LGBT+ staff networks and book club. A Menopause staff network, and leadership and management networking opportunities linked with our leadership masterclasses have embedded.
- Wellbeing conversation now embedded as 'check ins'.
- Quarterly "Wellbeing surgeries" which focus on a key topic, last surgery focused on men's mental health. Links have been established with internal and external stakeholders to offer a range of support options focussed on the themes identified such as mental wellbeing and long-term conditions.
- Virtual Occupational Health nurse Drop-in clinics
- Vaccination clinics to tackle emerging public health treats i.e.- pertussis
- Staff Wellbeing areas across both sites with good usage.
- Occupational Health and Wellbeing staff deliver sessions that are integrated within Managers essentials training, induction and Wirral Enhanced Preceptorship Programme (WEPP).
- A number of 'morale boosters' provided to staff including thank you breakfasts, staff awards, Christmas door competitions, gingerbread competitions, CSW / Nurses / HR Day all celebrated.

- Reward and recognition awards for staff
- Breakfast with Chief executive and other member of the exec teams
- Assessment of staff's measles immunity status undertaken, and MMR boosters offered as required.
- Psychoeducation session facilitated by OH Psychotherapist on Enhance Emotional Resilience & Staying Healthy and additional bespoke workshops on staff identified issues such as Low Mood, Social Anxiety, Post Traumatic Stress Disorder, Health Anxiety etc.
- Relaunch of Trust's Employee Assistance Programme (EAP) resulting in increased up take by 20%
- Health Surveillance policy and programme reviewed and re-launched.
- Launched the new EAP application Wisdom for all staff.
- ON site EAP presence quarterly in staff areas
- Achieved SEQOHS annual re-accreditation.
- Wellbeing walks during ongoing industrial action by service leads and professional nurse advocates (PNAs).
- Extra counsellor sessions via Red Poppy to support staff where required.
- Listening events within Divisions to understand individual service mental health needs and address these.
- Timely supervision and de-brief events held within clinical areas to support staff and help restore wellbeing following trauma.
- Freedom To Speak Up Leads undertake bi-weekly walk abouts.
- Menopause fast track clinic with access following triage to Consultant Gynaecologist.
- Talking Together Wirral with regular on-site presence in the patient experience HUB
- Staff Zumba sessions re launched/advertised
- Winter vaccinations programme
- Wellbeing Garden in Clatterbridge hospital
- Winter Wellbeing comms plan- 'countdown to Christmas'
- Comms campaign to re advertise how to self-refer into Occupational health and physiotherapy and how to make a good Occupational health referral
- ICB funded and produced digitalised document to sign post managers and keep details on how to make a good Occupational health referral in development
- MPOX plans for Occupational Health and staff risk assessments
- Health and wellbeing pages updated on the intranet
- Focused vaccination clinics in APH site
- Return to work guidance for respiratory infection reviewed and published
- Signed up to the Sexual Safety Charter
- Awards Bronze for antiracism charter

Areas of focus for the forthcoming year:

The Trust's People Strategy 2022-2026 has a significant focus on Wellbeing (within the Looking after ourselves and each other pillar) and sets out a vision and programme of work to continuously develop and embed a wellbeing culture across the Trust. Key priorities include:

- Deliver first class, innovative Occupational Health and Wellbeing Services by transforming our OH and Wellbeing Service to align to the Grow OH Strategy.
- Equipping our line managers and leaders with the knowledge, skills and tools to develop a wellbeing culture within their teams.
- Fully embracing flexible working across all roles through a programme of work to improve and promote the Trust's flexible working offer.

An annual delivery plan is produced for each year of the People Strategy, and it is anticipated that activities within the next year's delivery plan relating to Occupational Health and Wellbeing will include:

- Continue to produce plans for the Occupational health Department in alignment with the Grow OH strategy
- Phase two of the Cority system to be launched providing staff and managers an online portal
- Occupational Health Nurse led drop-in sessions.
- Proactive and reactive activities to address sickness absence at WUTH and support staff to stay well and in work.
- Continues implementation of the Well WUTH Back to Work programme following a successful pilot.
- One Wirral CIC performing health check to staff starting with Estates and Facilities
- Quarterly Wellbeing surgeries to have a focus on both physical and mental wellbeing.
- Proactive psychoeducation session to tackle stress and anxiety
- Neurodiversity drop-in sessions for staff ran by the sunflowers network
- Free menstruation products for staff as part of our commitment to addressing Period Poverty.

3.2 Cancer Services Annual Report

Summary of Achievements

- Secured funding for Cancer Services Project Staff and Macmillan Wirral Integrated Personalised Care Team scoping personalise care interventions, writing guidance and development of dashboard
- Increased user engagement events and outreach events
- Co-designed with people with lived experience a Local Cancer Patient Experience Survey
- MDT optimisation
- Developed tumour specific performance improvement plans
- Collaborative project launched to improve endometrial FDS performance
- Achieved NHSE recovery trajectory for 62 day target and reduced 62 day and 104 day long waiters
- Lung screening programme launched

Work plan 2025-2026

- Roll out new Local CPES and identify any areas for improvement
- Relocate and Launch Macmillan Cancer Information and Support Services centre
- Work with Macmillan Integrated Personalised Care project to develop an integrated model and education package
- Create system integration and BI tools to improve data completion and accuracy, performance and patient experience
- Develop competency frameworks for Band 4, 6 and 7 CSW and CNS
- Develop wellbeing away day for CNSs
- Monitor tumour site activity against best practice time pathways and identify areas of improvement
- Develop national and local initiatives within patient pathways to support improvement of 28 day faster diagnosis cancer standard

- Develop Annex 21 development program for MDT Co-Ordinators
- Improve data quality
- Work towards NHSE recovery trajectories
- Work towards optimising MDT optimisation

Cancer Patient Experience Survey (CPES)

Received some fantastic scores and feedback from the National CPES including:

- 8.9 (out of 10) for overall care (in line with National average)
- 61 questions – 37 were equal or above national average or improved from last year
- All 4 areas scoring 5% or more below NA last year showed improvements

3.3 Digitally Supported Arthroplasty Service shortlisted for HSJ Digital Awards 2026

Digitally Supported Arthroplasty Service has been shortlisted for the HSJ Digital Awards 2026 in the category Empowering Patients Through Digital. Launched in 2022, the service was a unique initiative designed to ensure every patient undergoing elective hip or knee replacement receives consistent, high quality information and support throughout their surgical journey. Since its launch, more than 2,800 patients have been recruited to the platform, with its reach continuing to grow. The service combines a user-friendly smartphone application with a web based clinical dashboard, creating an innovative digital platform that connects patients and clinicians. This approach supports effective management, timely communication, smarter workflows and improved outcomes before and after surgery. Being shortlisted is a fantastic achievement and a real testament to the hard work, innovation and commitment of the team. It also reflects the wider contribution of the Division in delivering high quality, patient centred care through digital innovation. This recognition provides a valuable opportunity to celebrate and showcase the excellent work being undertaken to support our patients

3.4 Neonatal Capital Project & ITU

• Charitable funds raised have funded a new Neonatal ITU.

• Increased cot side space to enhance family and staff experience.

• Improved flow through unit – reception and route via theatre

• Parent engagement session to inform the design.

• Refurbished Neonatal ITU opened Tuesday 9th December 2025

3.5 EDS Domain 1 Learning

Domain 1 of the Equality Delivery System (EDS) for 2025/26 was undertaken jointly with Wirral Community Health & Care NHS Foundation Trust. The assessment focused on an equality analysis of the two Musculoskeletal Physiotherapy services, which are at an early stage of integration as the two organisations move towards merger over the next 12 months.

Evidence was jointly collated across both services during Quarter 3 of 2025/26 and presented in January 2026 to a panel of internal and external stakeholders, including Healthwatch Wirral.

The evidence demonstrated several areas of outstanding practice across both services, particularly in relation to accessibility and a clear understanding of, and response to, the challenges experienced by people from some protected characteristic and inclusion groups. This was especially strong for service users with physical and mental disabilities or impairments.

Evidence relating to other protected characteristics was less consistent. In some areas, data was not available across both services for all protected characteristics, although there was evidence of actions being taken to address these gaps. Importantly, the review also highlighted that some of the identified good practice was not consistently applied across both services or across all protected characteristics and inclusion groups.

As a result of these evidence gaps, the panel graded the services as **Developing** rather than **Achieving** for Domain 1. However, the panel also recognised the significant progress made to date and commended the quality of practice already in place.

The key learning from Domain 1 is the importance of using this assessment to ensure that the good practice identified within each service is carried forward into the implementation of the new integrated service. In addition, equality data collection, recording, and analysis must be fully considered as part of the service integration process, particularly in relation to the Electronic Patient Record (EPR), to improve the availability and quality of equality data. Finally, it was noted that patient feedback mechanisms require further development to ensure accessibility for all service users, as alternative formats were not consistently available across both services

3.6 Recruitment event helped 21 Wirral residents secure job offers at WUTH as Healthcare Assistants

A successful partnership recruitment event at WUTH helped 21 Wirral residents secure job offers as Healthcare Assistants, allowing them to take their first steps into a career in the NHS.

The event, delivered jointly by WUTH, Wirral Council and Involve Northwest and Jobcentre Plus, focused on making the recruitment process more accessible for people.

3.7 New Breast Pain Clinic run by WUTH and in partnership with WCHC opened at Victoria Health Centre in Wallasey

A dedicated Breast Pain Clinic has opened at Victoria Health Centre, Wallasey, offering a new, patient-centred pathway for women experiencing breast pain as their only symptom.

The Breast Pain Clinic aims to significantly improve patient care and reduce anxiety for patients who would previously have been placed on a breast cancer diagnostic pathway involving tests and scans.

This service is run by Wirral University Teaching Hospital (WUTH) in partnership with Wirral Community Health and Care Trust (WCHC) to deliver care in the community. It's a 12-month pilot that has been made possible with funding from Cheshire and Merseyside Cancer Alliance (CMCA).

The new clinic offers faster access to specialist assessment and reassurance, while ensuring that anyone who does require further investigation can be referred immediately onto the cancer diagnosis pathway.

Many patients attending the clinic have been discharged with no further treatment needed.

Patient feedback has been overwhelmingly positive, with many saying that the quick access to care eased their anxiety and provided peace of mind.

3.8 WUTH teamed up with local charities to provide training sessions on autism and other neurodivergent conditions to its staff

WUTH teamed up with local charities to provide training sessions on autism and other neurodivergent conditions to its staff.

The training workshops were launched during World Autism Acceptance Month. Wirral-based charity Autism Together provided tailored training workshops to help WUTH staff understand the challenges faced by autistic people, both patients and staff, so that they can take actions to better support them. The training included two autistic people sharing their experience of how autism affects their lives, giving their personal accounts of how it can affect them each day.

The Brain Charity also delivered training for managers on neurodiversity, helping them understand how conditions such as autism spectrum condition (ASC), attention deficit hyperactivity disorder (ADHD), dyslexia, dyspraxia and dyscalculia can affect how people think, learn, and work, and how these differences can be strengths in the workplace. One of the key messages in the training was that autistic and other neurodivergent people do not all experience the same challenges, so finding out the needs of each person is essential to giving them the right support.

3.9 Same Day Emergency Care (SDEC) for Frailty patients

Incredible progress being made with Acute Frailty Services at WUTH, which are transforming how the Trust cares for older, more vulnerable patients.

Between 5% and 10% of patients that attend an Emergency Department, and up to 30% in Acute Medical Units, are older and frail. These patients are more likely to experience falls, delirium, disability, and readmission. Responding to these needs early is vital to improving patient outcomes and reducing unnecessary hospital stays.

The Acute Frailty Unit brings together same day emergency care (SDEC), frailty admissions, inpatient beds and the older person rapid assessment clinic.

It provides rapid, tailored assessments for patients aged over 65, supported by a fully co-located multidisciplinary team. This means that all the different healthcare professionals needed to care for a patient - nurses, doctors, physiotherapists, pharmacists, and others - are based in the same place and work closely together as one team, instead of being spread out across different parts of the hospital.

Early success in the first weeks of the project found that around 66% of patients seen in Frailty SDEC were able to return home on the same day. Patient feedback has also been overwhelmingly positive.

3.10 Pharmacy team were shortlisted for the HSJ Digital Awards

The WUTH Pharmacy team were shortlisted for the HSJ Digital Awards in the Improving Medicines Management and Pharmacy through Digital category, recognising an innovative project that improved access to critical medicines out of hours, delivered cost savings, and released pharmacist time to support clinical care.

The team were runners-up on the night, with the initiative also positively impacting staff recruitment and retention, with more trainees choosing to stay at the Trust. This national recognition highlights the team's commitment to improving patient safety, experience and workforce wellbeing through practical digital innovation.

3.11 WUTH's Practice Education Facilitators (PEF) Team has been recognised at the University of Chester CAPE Awards, which celebrate excellence in practice education across healthcare and academic settings

WUTH's Practice Education Facilitators (PEF) Team has been recognised at the University of Chester CAPE Awards, which celebrate excellence in practice education across healthcare and academic settings. The team works closely with wards and departments to provide high-quality learning environments for nursing and AHP students, ensuring they receive the support, supervision and experience needed to thrive in placements.

This year, WUTH's commitment to education and innovation was acknowledged across multiple categories, with the PEF Team winning Outstanding PEF Team of the Year and several colleagues receiving further awards and commendations. These achievements highlight the strength of WUTH's partnership with the University of Chester and the dedication of staff across the Trust in supporting and developing the next generation of healthcare professionals.

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

Gaps within placement rotations for doctors and dentists in training, alongside vacancies in other staff groups and increasing service demand, continue to present challenges for WUTH, as they do across the wider NHS. Rota gaps are influenced by a range of factors, many of which involve external stakeholder organisations including Foundation and Specialty training programmes, NHSE Workforce, Training and Education, and the Lead Employer. Variability in recruitment, differential fill rates across specialties, trainee leave, less-than-full-time working and attrition all contribute to the position.

Internally within WUTH, Medical Resourcing, Medical Education, Divisional Management Teams and the Guardian of Safe Working work collaboratively to monitor rota gaps and mitigate their impact on both educational experience and service delivery. Regular review mechanisms are in place to triangulate data from the National Training Surveys, local surveys, Exception Reporting which has seen a change of process with the introduction of the Exception Reporting Framework, Guardian of Safe Working and

feedback from the Junior Doctors Forum. This intelligence supports early identification of pressure points and informs targeted interventions.

Recruitment of locally employed (Trust grade) doctors and other experienced clinicians continues to play an important role in reducing the impact of gaps within training rotations. Where substantive recruitment is not possible, the Trust utilises internal staff banks and remains signed up to the North West Collaborative Bank to ensure that appropriately experienced doctors with the relevant competencies are able to support service delivery and maintain patient safety. Reducing reliance on agency staffing remains a priority.

In addition to recruitment measures, work is ongoing to strengthen rota design and governance. This includes improving forward planning, aligning rota capacity more closely with predictable leave, and increasing clinical input into rota development.

The Trust continues to align its approach with NHSE priorities, including the Improving Working Lives agenda and the 10-Point Plan, with a focus on enhancing flexibility, improving rota transparency and reducing duplication within training requirements to release time for both service and educational activity. Supporting trainee wellbeing and promoting a positive working culture remain central to retention and sustainability.

Collaboration between internal teams and external stakeholders is ongoing to identify further opportunities for improvement. The Trust remains committed to developing sustainable workforce solutions that reduce rota gaps, protect training quality and ensure safe, effective patient care.

3.13 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 2024/2025– Performance Metrics		
Performance Indicators	**Target**	**End of March 26**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	63.30%	64.75%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (Arrowe Park site)	66.34%	61.49%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (WUTH ED only)	53.7%	48.26%
C. difficile: variance from plan	103	141
Maximum 6-week wait for diagnostic procedures	95%	93.58%
Venous thromboembolism (VTE) risk assessment	95%	96.50%

3.14 Q4 Cancer Data

The below table shows the national cancer standard and the achieved percentage for the year 2025-2026 as a combined average for each quarter. The standard of maximum 14 days from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals was removed from the national cancer standards in October 2023.

National Cancer Standard	Description	National Cancer Standard Threshold	Q1	Q2	Q3	Q4
28 Days	Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	77%	70.80%	67.54%	67.62%	75.27%
31 Days	From Decision to Treat/Earliest Clinically Appropriate Date to Treatment of cancer	96%	91.56%	90.84%	90.20%	91.56%
62 Days	From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer	85%	73.79%	75.36%	72.86%	73.79%

It should be noted that for 2025-2026 the NHSE requirement was that (for all trusts) the position for the end of March 2026 for the 28-day standard should be >=80% and the 62 day standard >=75% regardless of the national cancer standard thresholds.

The 28-day expectation was based on the threshold for 28-day performance moving to be >=80% for 2026-2027.

The 62-day expectation was due to acknowledgement around prolonged recovery with the expectation trusts will be at >=75% by the end of March 2026 aiming for return to >=85% by the end of March 2029.

The trust 28-day performance for March 2026 was 84.05% and the 62-day performance for March 2026 was 75.86% i.e. both expectations for the trust for the end of March 2026 were met.

The trust has had to submit three recovery trajectories for 2026-2027, as part of NHSE operational planning guidance, which sets out month by month the expected level of performance for the 28-day, 31 day and 62-day standard. The trust has set ambitious targets as follows, in line with national expectations:

1. 28 day – to maintain >=80% throughout 2026-2027
2. 31 day – to achieve >=94% by the end of March 2027
3. 62 day – to achieve >=80% by the end of March 2027

Statement from NHS Cheshire & Merseyside Integrated Care Board (NHS C&M ICB)

Re: 2025/26 Quality Account Statement

Dear Christine

NHS Cheshire & Merseyside Integrated Care Board is pleased to endorse this Quality Account and confirms that it provides a clear, accurate and balanced reflection of the quality of care delivered by Wirral University Teaching Hospitals NHS Foundation Trust during 2025/26.

We recognise the significant operational and workforce challenges experienced by the Trust during the year and commend its leadership and staff for maintaining a sustained focus on patient safety, experience and outcomes.

NHS Cheshire and Merseyside recognise the strong progress made by the Trust in fully achieving two of its three quality priorities for 2025/26, alongside partial achievement of the remaining priority. The Trust has demonstrated clear and sustained improvement across its priority areas. Notable achievements include the successful trial of body-worn cameras within the Emergency Department, as well as the delivery of Trust-wide training to support the violence prevention and reduction priority. In addition, there is positive evidence of impact in relation to preventing deconditioning, supported by robust data, learning, and continuous improvement activity.

While the infection prevention and control priority has been partially achieved, we are encouraged by the actions being taken and remain committed to supporting the Trust's continued progress into 2026/27. We note a reduction in Clostridioides Difficile infections during 2025/26 compared with the previous year, reflecting sustained improvement efforts. However, the Trust exceeded the nationally set threshold and a continued focus on infection prevention and control remains a priority. Ongoing oversight and delivery of action plans will be key to providing assurance of further improvement.

Other notable achievements include the digitally supported Arthroplasty service, which has been shortlisted for the HSJ Digital Awards, demonstrating the delivery of smarter workflows and an enhanced patient experience. Additionally, the recruitment event that secured Healthcare Assistant roles for 21 Wirral residents represents an excellent example of effective system working, delivered in collaboration with Wirral Council, Involve Northwest and Jobcentre Plus.

We note that the Trust continues to make progress in embedding the Patient Safety Incident Response Framework (PSIRF), demonstrating a commitment to its ongoing development and integration across the organisation. Patient experience has remained positive, and workforce wellbeing continues to be prioritised.

The Trust's audit programme has been described within the account and assures oversight of clinical effectiveness with many audits highlighting key successes for the Trust. The findings described around paediatric diabetes, care at the End of Life and Oesophago-gastric cancer are positive, we will work closely with the Trust to understand more about the clinical audit findings requiring action during 2026/27 and support this delivery to allow further improvement journeys to be presented in the next quality account.

The Trust's open learning culture is clearly demonstrated within the Account, with particular emphasis on learning from mortality reviews. NHS Cheshire and Merseyside welcome the identification of key themes and shared learning.

NHS Cheshire and Merseyside acknowledge the Trust's four Never Events and will continue to engage in relation to the improvement actions that are being effectively overseen through robust internal quality governance processes.
We fully support the quality priorities for 2026/27, acknowledging the collaborative approach with Wirral Community Health and Care NHS Foundation Trust. The partnership priorities set out focus on reducing harm from pressure ulcers, falls, medicines, discharges and infection, which are well aligned with system and national priorities.

NHS Cheshire and Merseyside will continue to work closely with the Trust through ongoing regular contractual quality review and assurance processes, providing appropriate support and challenge where required.

Based on the evidence presented, we are confident that Wirral University Teaching Hospitals NHS Foundation Trust is committed to continuous improvement, and clearly focused on delivering safe, effective and compassionate care for the populations it serves.

Yours sincerely

Fiona Lemmens
Executive Clinical
Director
NHS Cheshire and Merseyside ICB

cc. Kerry Lloyd, Helen Meredith, Julia Bryant

Stay in Touch

Wirral University Teaching Hospital
Arrowe Park Road
Upton
Wirral
CH49 5PE

0151 678 5111

www.wuth.nhs.uk

@WUTHnhs

Need Help or Advice?

The Patient Advice and Liaison Service (PALS) focuses on improving services for NHS patients.

It aims to advise and support patients, their families and carers providing information on NHS services. PALS listen to concerns, suggestions or queries from our patients and people we care for helping sort out problems quickly on their behalf.

Contact PALS

By Phone: 0800 432 0251

By Email: wuth.patientexperience@nhs.net

You can ask a member of staff to contact PALS on your behalf