Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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Quality Account 2024-25

Contents

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NHS Foundation Trust

Our Mission, Vision, Aims and Values

Our vision for the future of Warrington and Halton Teaching Hospitals is to be a great place to receive healthcare, work and learn. We are committed to providing high quality, safe, and sustainable services, delivered by staff who are trained and supported to deliver their best, and we will work with our partners, across all levels of health and social care, the voluntary sector, and the independent sector, to achieve this and meet the needs of our local population. We have three strategic aims framed around Quality, People and Sustainability, which underpin our mission and vision.

Our Mission

We will be outstanding for our patients, our communities and each other

Our Vision

We will be a great place to receive healthcare, work and learn

Our Aims

QUALITY

We will always put our patients first, delivering safe and effective care and an excellent patient experience

PEOPLE

We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future

SUSTAINABILITY

We will work in partnership with others to achieve social and economic wellbeing in our communities

Our Values

Working Together

Excellence

Inclusive

Kind

Embracing Change

Our Strategic Quality Aim

The Trust has remained focused on the delivery of-the Strategic Quality aim which is linked to the achievement of the following 3 Strategic Objectives that are framed around -

- **Patient Safety,**
- **Clinical Effectivness**
- **Patient Experience**

Part 1

A Statement on Quality from the Chief Executive

and

Introduction from the Chief Nurse and Executive Medical Director

1.0 A Statement on quality from the Chief Executive, Nikhil Khashu

Warrington and Halton Teaching Hospitals NHS Foundation Trust is dedicated to the provision of high-quality care and clinical excellence. Recognising that our patients and staff deserve nothing less than outstanding, from all of the services that we deliver.

I am pleased to present to you Warrington and Halton Teaching Hospitals NHS Foundation Trust's Quality Account. The Quality Account is an annual report which reviews our performance and progress of the quality of healthcare services that we provide, whilst also acknowledging our commitment to improve further in the coming year 2025-2026.

The Quality Account provides the opportunity to reflect upon achievements, improvements and opportunities for learning, ensuring that patients and families receive the highest quality standard of care when they need it most. The Quality Account provides a progress report across a number of domains including the Quality Priorities that we focused upon in 2024-25.

Progress described within this document is based on data and evidence collected locally and nationally, much of which is presented as part of our performance framework each month in our Quality Assurance Committee, Council of Governors Meetings and public Board of Directors Meetings. We come to the end of 2024/25 not complacent, but with the immense pride in knowing we have performed well as an organisation against many of our key quality targets and quality indicators, details of the performance against these Quality Priorities are referenced at Part 2.

In Part 3, of this report we report on the performance of other relevant performance indicators and thresholds. We also set out the Quality Priorities agreed for 2025-26 which have been chosen based upon national and local drivers, our internal governance intelligence and following wide consultation and stakeholder engagement with patients, families, staff, Warrington Disability Partnership and the Integrated Care Board of Directors.

Information was also gathered to inform the Quality Account from the Patient Equality, Diversity and Inclusion Sub Committee, and Experts by Experience. Comments received from stakeholders on the content of the Quality Account are included verbatim in full in Annex 1 of this report. Warrington and Halton Teaching Hospitals, NHS Foundation Trust welcomes and encourages the involvement of all stakeholders to ensure that appropriate focus is provided in improving quality for the population that we serve. Similar to 2024-25 our Quality Priorities identified for 2025-26 will be delivered in accordance with our three domains of quality outlined below:

- **Priority 1 - Patient Safety:** We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.

- **Priority 2 - Clinical Effectiveness:** We will ensure practice is based on evidence so that we do 'the right things in the right way to achieve the right outcomes' for our patients.

- **Priority 3 - Patient Experience:** We will place the quality of patient experience at the heart of all we do, where "seeing the individual person not "the patient" is the norm.

I am pleased to present this year's Quality Account outlining the embedded governance processes that have allowed myself and the Trust Board of Directors to authorise this document as a true and actual account of quality at Warrington and Halton Teaching Hospitals NHS Foundation Trust. I am proud of what we have achieved as a Trust and wider health system in 2024-25.

Moving forward to 2025-26 we will continue to make good progress on our integration plans with Bridgewater Community Health Care NHS Foundation Trust to become one single organisation, subject to the necessary NHS regulatory approvals. This change will help us to achieve our ambitions and deliver the greatest benefits for our patients and staff. I look forward to continuing to work collaboratively as a system to enhance the standard and quality of care delivered across both organisations throughout 2025/2026.

To the best of my knowledge, the information contained within this report is accurate and provides a balanced account of the quality of services we provide.

Nikhill Khashu
Chief Executive

23 June 2025

1.1 Introduction from Ali Kennah, Chief Nurse and Paul Fitzsimmons, Executive Medical Director

At Warrington and Halton Teaching Hospitals NHS Foundation Trust, we are committed to building a culture of continuous quality improvement, ensuring that the voice of staff and patients is heard. We continue to work towards our 'Five essentials of continuous quality improvement' which are:

- Understand
- Define
- Develop
- Test
- Embed

These 5 essentials of continuous quality improvements provide a framework and foundation to drive improvement and successfully implement sustainable change. This focused approach alongside other functions, including the Patient Safety Incident Response Framework (PSIRF) and our cultural Programme, will support us to harness a patient safety and learning culture.

Our implementation of the PSIRF continues to be successful, making use of new tools and techniques to adopt a system thinking approach to our learning, supported by our patient safety partners and specialists. This, alongside the continuation of developing a research active workforce, will contribute not only to current improvements but more widely to the health of our population in the future.

We are so very proud of all of the hard work undertaken across Warrington and Halton Teaching Hospitals NHS Foundation Trust, recognising the challenges that all healthcare providers continue to face. We are committed to continue to lead the Trust with vision and clarity towards our ambition to be rated as 'outstanding' for our patients and their families. The dedication of all staff has led to tangible improvements across the quality agenda during 2024-25 and this commitment is set to continue in the forthcoming financial year.

Ali Kennah
Chief Nurse

Paul Fitzsimmons
Medical Director

Part 2

Priorities for Improvement and Statements of Assurance from the Board of Directors

WHAT IS A QUALITY ACCOUNT?
Quality Accounts are annual reports to the public from us about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to defining our priorities for the next year to indicate how we plan to achieve these, and quantify their outcomes.

2.0 Priorities for Improvement and Statements of Assurance from the Board of Directors.

This section details:

- **How we will monitor, measure and report on Quality Priorities to achieve our priorities for quality improvement.**
- **Looking back - A review of the Quality Priorities that were agreed during 2023-24.**
- **Performance against the agreed Quality Priorities for 2023-24.**
- **Information regarding the Statements of Assurance which is mandatory text that all NHS Foundation Trusts must include in their Quality Account.**

A Programme of work was established that corresponded to each of the quality improvement areas targeted. Each individual scheme within the Programme has contributed to one, or more, of the overall performance targets set by Warrington and Halton Teaching Hospitals, NHS Foundation Trust. Considerable progress and improvements have been delivered through the commitment of staff to influence and sustain improvements.

Comparative performance benchmarked data.

Wherever applicable, the Quality Account will refer to performance in previous years and comparative performance benchmarked data with other similar organisations. This will assist in understanding progress over time and is a means of demonstrating performance compared to other organisations. This will help to add context to the data provided. Wherever possible, references to the data sources for the quality improvement indicators/priorities will be stated within the body of the report or within the Glossary of Abbreviations and Glossary of Terms, including whether the data is governed by national definitions.

Organisational Structure - How we will monitor, measure and report on-going progress to achieve our priorities for quality improvement.

The Trust's organisational structure enables Warrington and Halton Teachings Hospitals NHS Foundation Trust to be responsive to challenges, through effective clinical engagement with strong and resilient leadership at all levels to deliver the best outcomes for patients. This is achieved through a variety of methods including continuous quality improvement, transformation and research and innovation.

The structure was developed collaboratively with stakeholders to deliver care and services utilising a 'Care Group' model which consists of various clinical specialities within a Clinical Business Unit (CBU) structure. There are three Care Group structures at Warrington and Halton Teachings Hospitals NHS Foundation Trust; Planned Care, Unplanned Care and Clinical

Support Services all of which work with a Triumvirate leadership model to deliver a high quality and cost-efficient service. Warrington and Halton Teachings Hospitals NHS Foundation Trust has seven Clinical Business Units which are responsible and accountable to the relevant Care Group. These report through to the appropriate senior team and the Executive Directors.

The Trust's organisational structure embraces the concept of a compassionate leadership with the Triumvirate model bringing together a wealth of knowledge and expertise amongst senior doctors, senior nurses/Allied Health Professionals and senior managers, all of whom work collaboratively to ensure efficiencies across clinical, operational and financial requirements.

The information presented in the Quality Account represents information from the Clinical Business Units, supported by Corporate Services which has been monitored over the last 12 months by the Patient Safety and Clinical Effectiveness Sub Committee, Quality Assurance Committee, Council of Governors, Trust Board of Directors, and the Integrated Care Board.

2.1 Looking Back - Performance against Quality Priorities for 2024-25.

The following Quality Priorities were identified and agreed for implementation in 2024-25. These are referenced in accordance with the three domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience.

Throughout the year the progress on each Quality Priority for 2024-25 is reported and monitored on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee, Quality Assurance Committee. Council of Governors, Trust Board of Directors, and the Integrated Care Board.

2024-25 Quality Priorities

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

The improvement aims	Description of Quality Priorities	The outcome
Improve patient safety	1. Ensure that all patients within the Emergency Department receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes 2. Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%. 3. Reduce the number of category 2 pressure ulcers by 20% with zero tolerance of category 3 and category 4 pressure ulcers	**Patient safety is enhanced through a learning culture where quality and safety is everyone's top priority**
Improve clinical effectiveness	4. Improve Theatre Safety with a focus on improving safety culture and compliance with Safe Surgery Safety Standards 5. Delivery of the trust wide improvement programmes across all Care Groups aligning to GIRFT recommendations to support timelier and more effective patient care 6. Continue to embed Patient Safety Incident Response Framework by developing and maintaining effective systems and responses for responding to patient safety incidents across the Trust.	**Practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients**
Improve patient experience	7. Ensure that the Trust is compliant with the Mental Health Act legal processes and administration, evidenced through achieving a minimum of 95% compliance in the quarterly compliance report. 8. Reduce internal Hospital delays related to discharge planning to support safe and effective discharge, this will be evidenced through a reduction in failed discharges and a reduction in patients with 'no criteria to reside' averaged over 12 months 9. Improve the compliance with the Nutritional Assessment of Adult inpatients utilising the Malnutrition Universal Screening Tool (MUST). The overall target of the Trust is to achieve 95% compliance with assessment being completed within 24 hours of admission and then as a minimum every 7 days during their inpatient stay. With an aim to improve on current compliance in both metrics by 25% this year and to provide assurance that the appropriate level of intervention is provided to support patients in relation to their assessed needs and improve clinical outcomes.	**The quality of the patient experience is at the heart of all we do and 'seeing the person in the patient' is the norm**

Quality Priorities for 2024-25 and the information below contains an update on progress on each of the Quality Priorities under the three domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience.

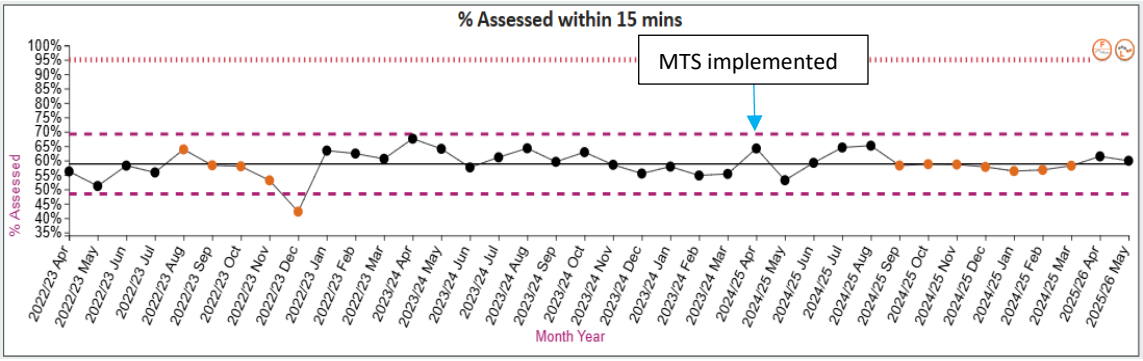
Patient Safety

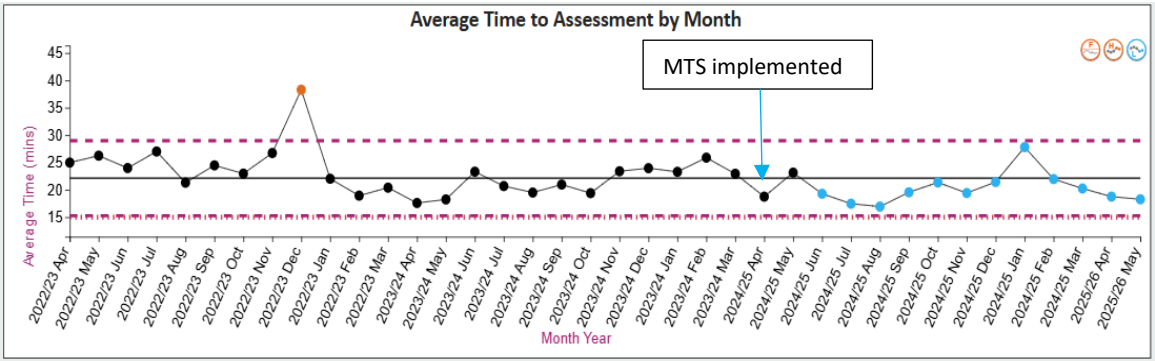
Patient Safety - We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority.
1. Ensure that all patients within the Emergency Department receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes **Leads:** Zoe Harris, Director of Operations and performance, Deputy Chief Operating Officer/Sharon Kilkenny, Associate Director of Unplanned Care/Emma Painter, Associate Chief of Nursing for Unplanned Care
What success will look like
1. Embedded the Manchester Triage Score (MTS) system to support achievement of all Type 1 and Type 3 patients receiving primary Triage within 15 minutes of arrival in the Emergency Department (ED). (A Type 1 service is a Consultant -led 24 -hour service with full facilities for resuscitating patients and accommodation for the reception of ED patients. A Type 3 service treats at least minor injuries and illnesses and can be routinely accessed without appointment.) 2. Improved streaming pathways to all assessment areas - ED Ambulatory, Minors, Medical Same Day Emergency Care (SDEC), Surgical SDEC, Frailty Assessment Unit (FAU), Gynaecology Assessment Unit (GAU) and Paediatric Assessment Unit (PAU). 3. Implement and embedded Rapid Assessment and Treatment (RAT) system for ambulance arrivals in ED.
Q4 progress/summary
Objective 1: **Have all measures/monitoring been achieved.** • Manchester Triage Score (MTS) was rolled out within the Emergency Department, UTC (Urgent Treatment Centre) and SDEC (Same Day Emergency Care) areas in April 2024. The performance standard within SDEC is not monitored nationally but is locally monitored, in the Trust. **Improvement outcomes** • At the start of Quarter 1 (April 2024) 64.22 % Type 1 and Type 3 patients, were assessed within 15 minutes with an average Triage time of 18.76 minutes. At

the end of Quarter 2 (September 2024) 58.28% Type 1 and Type 3 patients, were assessed within 15 minutes with average Triage time of 19.55 minutes.

- At the end of Quarter 3 (December 2024) 61.60% of Type 1 and Type 3 patients, were assessed within 15 minutes with an average Triage time of 18.65 minutes.
- At the end of Quarter 4 (March 2025) 58.21% of Type 1 and Type 3 patients were assessed within 15 minutes. Type 1 – 52.83% and Type 3 – 69.85%. With an average Triage time of 20.25 minutes. Type 1 – 23.73 minutes and Type 3 – 12.72 minutes.

Type 1 and Type 3 performance





- At the start of Quarter 1 (April 2024) 40.18% SDEC patients, were assessed within 15 minutes with average Triage time of 26.27 minutes. At the end of Quarter 2 (September 2024) 63.77% SDEC patients, were assessed within 15 minutes with average Triage time of 14.54 minutes.
- At the end of Quarter 3 (December 2024) 62.39% of SDEC patients were assessed within 15 minutes, with an average Triage time of 15.02 minutes.
- At the end of Quarter 4 (March 2025) 68.66% of SDEC patients were assessed within 15 minutes, with an average Triage time of 14.23 minutes.

Key Learning

- The embedding of the process has received additional support during July and August for staff who predominantly work nights and weekends as these were the times where performance was lower, however the improvements seen during this period were not sustained in September 2024. Actions for improvement continue, this is monitored through the Triage Improvement Meeting.
- The improvements made in the performance within SDEC have far exceeded those made within Type 1 and Type 3 and the teams are working together to understand if they are able to learn from SDEC to improve performance in their own areas.
- The SDEC position at the end of Quarter 3 has remained stable with consistent performance being seen. Type 1 and Type 3 performance has seen improvement from Quarter 2. Triage is now registered as a Matron led QI project and a relaunch presentation has been delivered.
- At the end of Quarter 4 Type 3 and Type 5 (SDEC) continue to perform consistently well against the Triage metrics and have done for the previous 10 months. Focus remains on Type 1 Triage for both walk in and ambulance arrivals.
- Triage roles (RN/HCA) have been redefined to save essential minutes when undertaking the Triage process. The role of the NWAS Corridor Nurse is also being reviewed to ensure workload is manageable and able to support all necessary elements, including Triage.
- Through the Triage, Streaming and Deflection Group, a performance trajectory is being produced to track progress.

Objective 2:

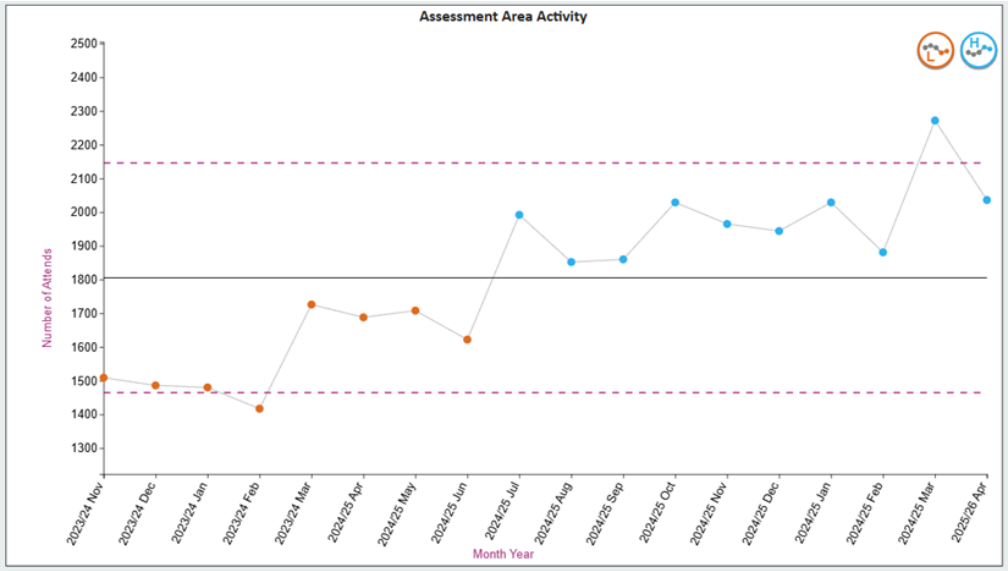
Have all measures/monitoring been achieved.

- The aim is to change the method for recording of activity across all assessment areas (ED, Ambulatory, Minors, Medical SDEC, Surgical SDEC, Frailty, GAU and PAU to Type 5 (Type 5 are patients who are deemed to require Ambulatory Emergency Care Services) and to increase the number of patients being streamed to these areas to reduce crowding in the ED.
- Type 5 has been implemented in Gynaecology Assessment Unit (GAU) and Frailty Assessment Unit (FAU). The implementation in Peadiatric Assessment Unit (PAU) has been delayed due to safety concerns regarding prescribing and workforce constraints which could cause risk to patients receiving timely medications. This is currently on hold but is being discussed at a regional level.

Improvement outcomes

- The number of patients being streamed to Type 5 areas has significantly increased.

Number of patients streamed to asssessment areas



Key Learning

- The Urgent and Emergency Care (UEC) Team are reviewing how quickly patients are being streamed from the ED to the assessment areas.
- The UEC Team are reviewing data for assurance that all patients who meet the criteria for streaming are being streamed to establish if there is opportunity to reduce occupancy further. This work remains on-going with a focus on the SDEC and ED Ambulatory pathways.
- At the end of Quarter 4 (March 2025) assessment area activity saw a significant increase across SDEC, ED SDEC and GAU with FAU activity remaining consistent.
- A Programme workstream for Triage, streaming and deflection is in place to support the 78% improvement Programme.
- Work is on-going in relation to review of SDEC pathways and staffing plans.

Objective 3:

Have all measures/monitoring been achieved.

- The aim is for patients arriving by ambulance to be seen by a senior member of staff and have diagnostics requested and initial treatment started as soon as possible after arrival. Due to occupancy pressures within the ED, it has not always been possible to ring fence the Rapid Assessment and Treatment (RAT) area for its intended purpose, which has culturally posed some challenges in sustaining the process.

- There has been full engagement with the ED Team through Consultant and nursing meetings, daily huddles, and newsletters.

Key Learning

- It has been difficult to measure improvements due to the limited data we are able to extract from the Trust Electronic Patient Record (EPR) system. The UEC Team are working with the information department to establish how this could be achieved without increasing administrative burden on the Clinical Team. Opportunities to improve the way this activity is recorded continue to be explored.

Has this Priority been achieved	Actions being taken
Partial	The Trust is currently partially achieving this Priority. However, significant improvements have been made in the performance within SDEC (Same Day Emergency Department) have far exceeded those made within Type 1 and Type 3 and the teams are working together to understand if they are able to learn from SDEC to improve performance in their own areas.

2. Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

Lead: Planned Care Triumvirate/Clinical Support Services Triumvirate/Unplanned Care Triumvirate/Zoe Harris, Director of Operations and Performance, Deputy Chief Operating Officer

What success will look like

1. Achieving the trajectory of 95% as an aggregate.

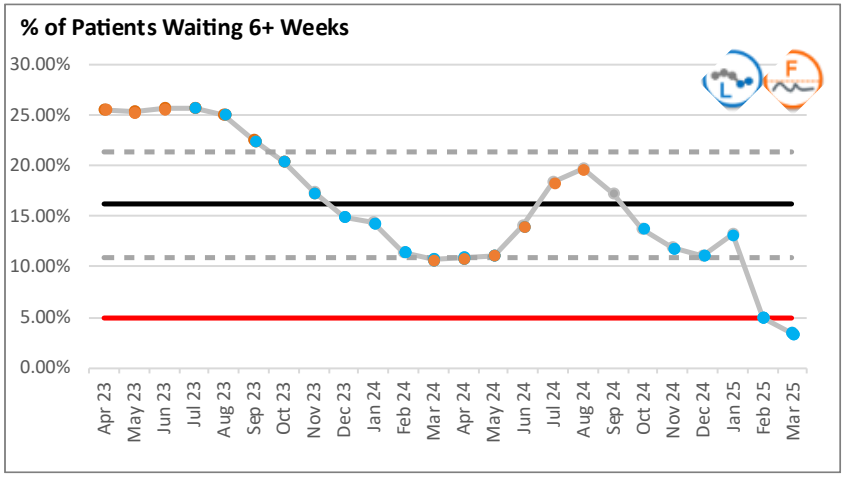
Q4 progress/summary

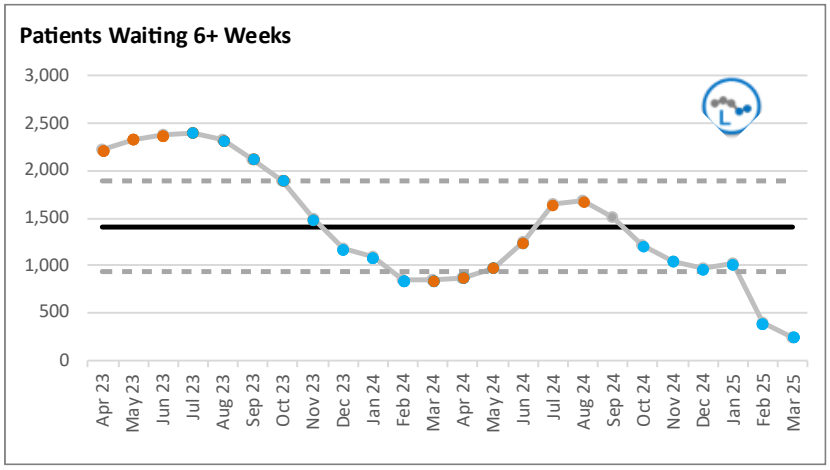
Have all measures / monitoring been achieved.

- Diagnostic Waiting Times and Activity (DMO1) performance has recovered at an aggregate position in February 2025 which is a month earlier than planned.
- Currently 6/15 modalities are fully recovered, challenges in Cystoscopy and Echo remain.

Improvement outcomes

- Improvement outcomes are measured as compliance against trajectory. DMO1 is currently reporting at **96.65%** (March 2025) at an aggregated position which is a recovered position.





- Modalities not achieving include:
  - Endoscopy: Cystoscopy, Colonoscopy, Gastroscopy, Flexi Sigmoidoscopy
  - Respiratory Physiology (Sleep)
  - Echo
  - Urodynamics (Gynaecology)
  - The main reason for the above not being achieved was workforce vacancies and delays in the Endoscopy Hub opening.

Key Learning

- Endoscopy Hub is now fully operational.
- Equipment constraints in Urodynamics, will be resolved with the purchase of an additional scanner.

Has this Priority been achieved	Actions being taken
	This priority has achieved over the expected goal of 95%.

3. Reduce the number of Category 2 pressure ulcers by 20% with zero tolerance of Category 3 and Category 4 pressure ulcers

Lead: Tracy Fennell, Deputy Chief Nurse/Director of Governance and Director of Governance/Deb Howard, Associate Chief Nurse for Corporate Services/Heather Aston, Tissue Viability Clinical Nurse Specialist

What success will look like

To deliver the expected outcomes of the below 3 improvement actions.

1. Ensure accurate assessment, documentation, and categorisation for patients at risk of pressure damage.
2. Monitored and reported on the Integrated Performance Dashboard to Quality Assurance Committee and to the Clinical Quality Focus Group.
3. Learning actioned and evidenced

Q4 progress/summary

Objective 1:

- The table below provides CQUIN compliance information for Q4. To achieve compliance, all elements of the objective need to be achieved including:

  - Pressure Ulcer Risk Assessment (Waterlow) completed within 6 hours of admission.
  - Pressure Ulcer Prevention Care Plan completed within 24 hours of admission (if Waterlow over 10).
  - Pressure Ulcer Risk Assessment (Waterlow) updated every 30 days during admission.

Q1	Q2	Q3	Q4
48.21%*	**51.58%***	**50.56%***	**50.36%**

Taken from spreadsheet 14/04/25. Note 2023/24 baseline 47.27%.
***Adjusted from previous report.**

- As separate elements, completion of the Waterlow within 6 hours in Q4 is 72.39% which is within target, however a decrease from an adjusted 76.11% in Q3.
- Completion of a repeated Waterlow every 30 days in Q4 is 92.44% which is an increase from an adjusted 91.87% in Q3.

- Completion of care plan within 24 hours (if Waterlow is over 10) in Q4 is 33.09% which increased from an adjusted 27.38% in Q3.
- There have been 27 more Category 2 pressure ulcers in 2024/25, from 128 in 2023/24 to 155 in 2024/25, an increase of 21%.
- Since 01 April 2024, pressure ulcers are no longer categorised as unstageable. They are now identified as a minimum Category 3 pressure ulcer (complies with national guidance).
- There have been 7 less Category 3 pressure ulcers in 2024/25 from 16 in 2023/24 to 6 in 2024/25, a reduction of 44%.
- There have been no Category 4 pressure ulcers in 2024/25. This is one less than in 2023/24.
- While the total number of pressure ulcers has increased by 13% in 2024/25, the severity of harm has decreased.

Improvement outcomes

- A Pressure Ulcer Task and Finish Group was previously established by the Deputy Chief Nurse/Director of Governance. Assessment and documentation relating to pressure ulcers has been an area of focus including piloting of an updated ASSKING (Assess Risk, Skin Assessment and Skin Care, Surface, Keep Moving, Incontinence or increased moisture) bundle, mapping of current practice against national guidelines, initial planning for replacement of Waterlow with Purpose. The work of the group has concluded. Outstanding actions are monitored through separate workstreams.
- While a fixed term post was initially approved to support the roll out of Purpose T, the plan was amended and was covered by bank hours within the team (CPD funded to cover the education and training component). Additional hours have also been agreed to continue support of the roll out of Purpose T in May 2025.
- In October 2024, Pressure Ulcer Review Meetings commenced to support identification of themes following After Action Reviews.
- Pressure Ulcer Prevention Training compliance has been above the Trust target of 85% since November 2024
- Review validator training progression.
- Ward/department walk arounds commenced in April 2025 by Deputy Chief Nurse/Director of Governance and Associate Chief Nurses. The purpose of the walk around was to review pressure ulcer prevention standards of practice in clinical areas.

Key Learning

- A continued focus is required on completion of care plans to support pressure ulcer prevention work. Information regarding compliance has been shared at Compliance Meetings with the Deputy Chief Nurse/Director of Governance.
- The possibility of mandating completion of the care plan within Lorenzo for Waterlow scores above 10 is not possible within the system.

Objective 2:

Have all measures / monitoring been achieved.

- Incidence of pressure ulcers reported through Clinical Business Unit (CBU) High Level Briefing Papers (HLBP) to OPSG (Operational Patient Safety Group) and through the monthly Integrated Performance Report (IPR) Quality Dashboard to Quality Assurance Committee (QAC).
- A deep dive on pressure ulcers was presented to QAC in Q3.
- A Pressure Ulcer Monthly update is prepared for OPSG. This update includes SPC charts for the wards were there are the highest incidence of pressure ulcers in month which is included in the HLBP for PSCESC.

Improvement outcomes

- No changes planned at present.

Key Learning

- With effect from April 2024, the category of unstageable is no longer used and they are reported as a minimum Category 3.

Objective 3:

Have all measures / monitoring been achieved.

- After Action Reviews have been completed following detection of a pressure ulcer. Themes are shared at OPSG.

Improvement outcomes

- AAR (After Action Reviews) continue to be completed following the detection of a Category 2 pressure ulcer.
- In October 2024, Pressure Ulcer Review Meetings commenced to support identification of themes following After Action Reviews.
- All pressure ulcers minimum Category 3 and above will be reviewed at the Pressure Ulcer Review Meeting and if required an MDT (Multi-Disciplinary Team) or ISR (Initial Safety Review) to be completed. TVNs (Tissue Viability Nurse) to be part of this review, from which lessons learned can be shared through OPSG, Ward Managers Meetings and through training.

Key Learning

- Prolonged time in the Emergency Department.
- Long lies prior to admission.
- Delay in obtaining pressure relieving equipment/delays in upgrading mattresses.
- Repositioning was not always frequent enough.
- Early signs of pressure damage not acted upon.
- Risk assessments delayed or not acted upon.
- Delay in commencing pressure ulcer prevention care plan.
- Medical devices.
- Heels not relieved of pressure.

Are we on track to meet this priority? Use RAG rating to assess the status of key actions based on your work plan.
RAG: Amber

	2023/24	2024/25	Mean 2023/24	Mean 2024/25
Category 2	**128**	**155**	**10.7**	**12.9**
Category 3/ unstageable*	**16**	**9**	**1.3**	**0.5**
Category 4	**1**	**0**		
Totals	**145**	**164**	**12.1**	**13.4**

* Unstageable is no longer a classification in 2024/25

RAG	Description
Grey	Action not yet started
Red	Action behind schedule with no mitigation
Amber	Action behind schedule with mitigation
Green	Action on schedule or ongoing
Blue	Action complete

Has this Priority been achieved	Actions being taken
Partial	Although the Trust is currently partially achieving this priority. Some elements of this priority we are achieving, as follows: • Completion of Waterlow within 6 hours. (72.39%)

	• Completion of a repeated Waterlow every 30 days (92.44%) The element of this priority not being achieved is: • Completion of care plan within 24 hours (if Waterlow is over 10) (33.09%) The following is being undertaken with an aim to improve compliance: • Assessment and documentation relating to pressure ulcers has been an area of focus including piloting of an updated ASSKING (assess Risk, Skin Assessment, and Skin Care, Surface, Keep Moving, Incontinence or increased moisture). • Pressure Ulcer Review Meetings commenced in October 2024 to support identification of themes following after action reviews.

Clinical Effectiveness

Clinical Effectiveness: Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.
4. Improve Theatre Safety with a focus on improving safety culture and compliance with Safe Surgery Safety Standards **Lead:** Planned Care Triumvirate/Dr Kevin Tan, Deputy Associate Medical Director for Clinical Effectiveness/Dr Mithun Murthy, Associate Medical Director for Clinical Effectiveness
What success will look like
To deliver the expected outcomes of the below 3 improvement Programmes 1. **Audit/checklists**: Implementation of improved NatSSIPs 2 Theatre checklists across all Theatre areas and ensure > 90% compliance with the audit. 2. **Incidents/governance**: Establish and monitor a triangulated feed of procedure related Datix's (and any Never Events) via Patient Surgical Safety Group (PSSG), with investigation of any future ever events via PSIRF (Patient Safety Incident Response Framework) methodology. 3. **Culture:** Utilise AHRQ (Agency for Healthcare Research and Quality) SOPS survey results to improve safety culture in Theatres, with focus on the expansion of human factor training across the Theatre Teams, simulation & monitoring

anti-social behaviour incidents, ultimately feeding into Theatre Culture Working Group.

Q4 progress/summary

Objective 1:

Have all measures/monitoring been achieved.

- All 11 recommendations from Theatres Safety Day (December 2023) have been completed with follow up actions monitored via PSSG (Procedural Safety Steering Group).
- Action plan from MIAA external audit was completed and is tracked via PSSG and QAC.

Improvement outcomes

- MIAA external audit was undertaken in December 2024 and reported in January 2025. The audit resulted in a 'Limited Assurance' opinion. There were several key findings split into High risk (3) and medium risk (4). A Trust response and detailed action plan against each action was presented at the Quality Assurance Committee (QAC) on 08 April 2025.

Number of Actions	Status	Due Date
12	Completed	N/A
4	On Track	30/04/2025
2	Not Started	31/06/2025

- A full risk assessment was also completed against all the actions.

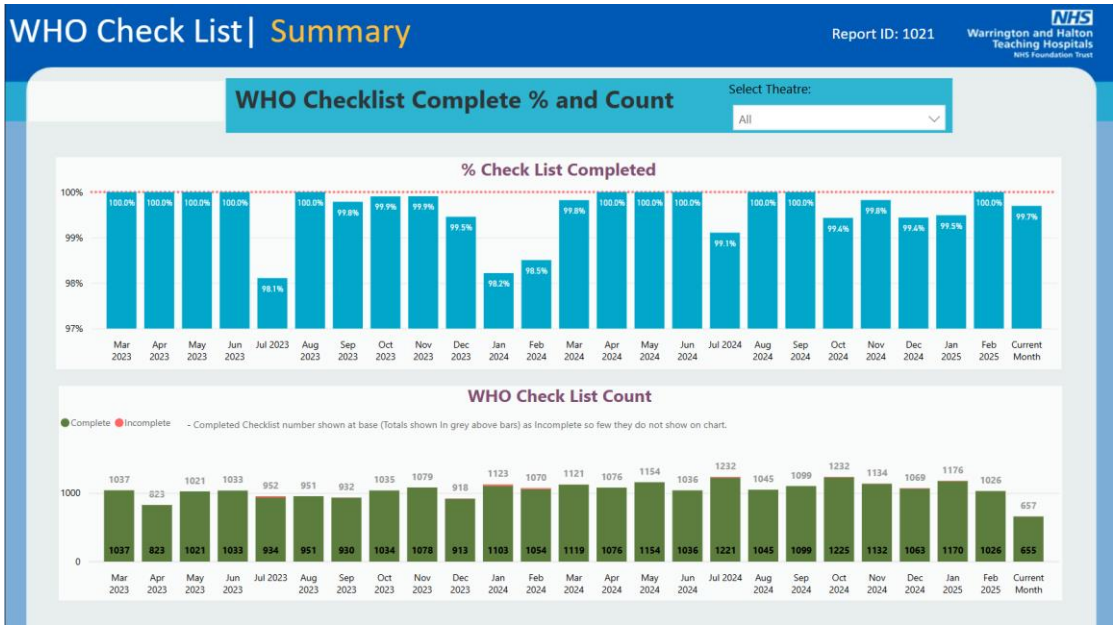
Summary of key immediate actions

- Frequency of WHO checklist audits increased to 5 audits per week per site.
- A dedicated team have been assigned for the ownership and monthly collation of audits. Both observational and documentation audits.
- A role profile for the Surgical Safety Champion has been developed. Whilst awaiting appointment, the role requirements are being fulfilled by The Lead Nurse and Matron of Theatres.
- The audit department has been authorised to undertake the role of "quality auditors."
- A rota for operational colleagues has been developed to undertake the role of "secret shoppers."

- The Terms of Reference (TOR) for PSSG has been reviewed and amended to ensure more direct oversight and accountability for the Theatres Team, with monthly meetings and dedicated monthly HLBP to PSCESC.

NatSSIPs 2 audit compliance for last Quarter below (using new tool) –

- Jan ’25 = 99.5% (n=1176)
- Feb ‘25 = 100% (n=1026)
- Mar ‘25 = 99.7% (n= 657)



Key Learning

- Immediate improvement works following previous never events (action cards/ sound ears/swabsafe trays) have had a positive impact.
- A dedicated team have been assigned for the ownership and monthly collation of audits. Both observational and documentation audits.
- A rota for operational colleagues has been developed to undertake the role of “secret shoppers.”

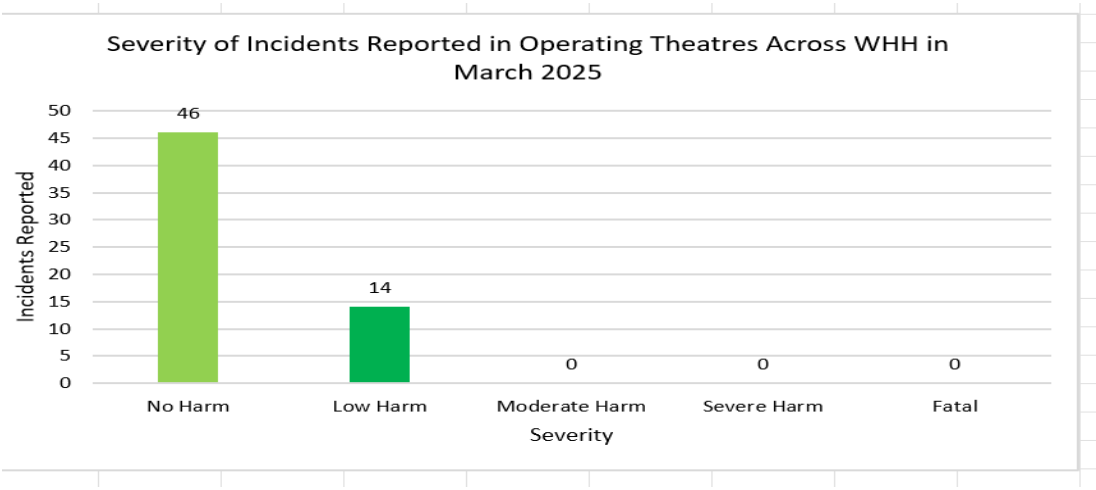
Objective 2:

Have all measures/monitoring been achieved.

- Governance and Quality Academy (audit/ CQI) representation now well established at PSSG.
- Automatic feed of governance information via governance dashboard has been set up and is fully discussed at PSSG.

Improvement outcomes

- There have been no further never events since January 2025.
- Severity of incidents reported in Theatres are no/low harm as below for March 2025.



- The Audit Department has been authorised to undertake the role of "quality auditors."

Key Learning

- Datix incident codes may be not fully representative of themes. Meeting to be set up to re-align codes to be able to better pull thematic data in future.
- Medical staff DATIX reporting rates still low (in line with AQuA survey results). This has been escalated to The Planned Care Associate Medical Director. Various safety culture and governance workshops held, especially for Surgical & Anaesthetic Medical Staff to improve awareness of governance issues and safety culture e.g. 'Civility workshop' via external speaker.

Objective 3:

Have all measures/monitoring been achieved.

- All Theatres culture work is now taking place via a Theatres Culture Working Group spearheaded by the planned care triumvirate with regular monthly meetings.

Improvement outcomes

- Senior Theatre staff training in Human actors is ongoing.

- Further regular safety simulation work across all Theatre areas involving all members of staff as per SMART action plan below.

Action	Date planned	Deadline	RAG rating
Contact and involve Trust Simulation Lead	7.3.25	19.3.25	
Appointing Lead for Simulation Program for Theatres - trial at Warrington	7.3.25	1.4.25	
Contact and involve Anaesthetic Human Factor and Simulation lead	7.3.25	19.3.25	
Coordinating twice a year session Simulation sessions have been confirmed by anaesthetic ACSA lead embedded into annual program	TBD by joint surgical and anaesthetic governance leads	TBD by joint surgical and anaesthetic governance leads	
Simulation planning	Team to plan at the time		
Embedding program	7.3.25	1.9.25	

Key Learning

- Ongoing work in Theatres safety culture led by the Planned Care Triumvirate with support from OD/People's Directorate via the Theatres Culture Working Group.

Has this Priority been achieved	**Actions being taken**
Partial	This priority is currently partially achieved with full mitigation in place as noted above.

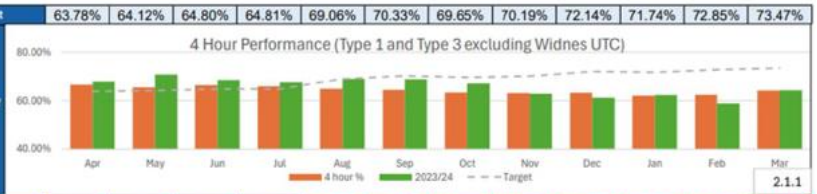
5. Delivery of the Trust wide improvement Programmes across all Care Groups aligning to GIRFT recommendations to support timelier and more effective patient care **Lead**: Beth Jacobs, Head of Improvement/Claire Leather, Head of Finance GIRFT (Getting it Right First Time)
What success will look like
To deliver the expected outcomes of the below 3 improvement Programmes

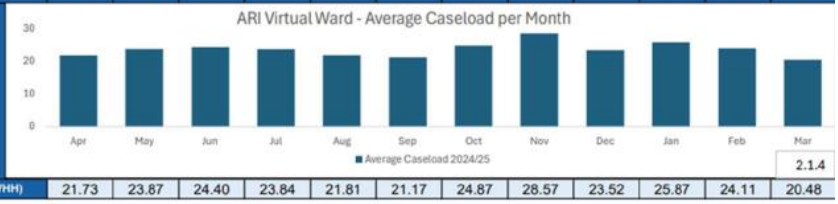
1. UEC Internal and System Improvement Programme
2. Theatre Improvement Programme
3. Outpatient Improvement Programme

Q4 progress/ summary

Objective 1:

Have all measures/monitoring been achieved.

Metric Description	Baseline		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Target of 78% of patients being admitted, transferred, or discharged within four hours in the Emergency Department. This metric is Type 1 and Type 3 and excludes Widnes UTC.	4-Hour Performance	Target	63.78%	64.12%	64.80%	64.81%	69.06%	70.33%	69.65%	70.19%	72.14%	71.74%	72.85%	73.47%
		(reduction of 28 p.w)												
		Actual	66.56%	65.45%	66.36%	65.85%	64.83%	64.37%	63.27%	63.02%	63.21%	62.09%	62.42%	64.09%
No patient should wait longer than 12 hours from time of decision to admit to transfer to a ward.	12-hour Performance	Target (WHH)	19.5%	19.0%	18.5%	18.0%	17.5%	17.0%	16.5%	16.0%	16.0%	16.0%	15.5%	15.0%
														
		Actual (WHH)	20.1%	19.9%	18.8%	19.2%	18.2%	18.9%	23.4%	17.9%	22.4%	26.4%	24.1%	19.8%
Bed Occupancy shows the number of occupied bed days as a percentage of all available bed days during the period. This excludes assessment, maternity and paediatric beds.	Bed Occupancy	Target	89.30%	89.88%	92.12%	92.66%	92.78%	92.96%	95.22%	93.26%	92.28%	95.37%	94.65%	94.66%
														
		Actual	96.55%	96.85%	97.07%	96.81%	96.84%	97.14%	97.24%	96.71%	95.25%	97.01%	96.16%	97.05%

Metric Description	Baseline		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Virtual Ward	ARI Virtual Ward Average Caseload per Month													
		Actual (WHH)	21.73	23.87	24.40	23.84	21.81	21.17	24.87	28.57	23.52	25.87	24.11	20.48
Virtual Ward	Frailty Virtual Ward Average Caseload per Month													
		Actual	5.07	5.90	6.40	8.10	9.29	9.50	9.74	10.27	11.03	10.81	11.54	11.29
Discharge Lounge	Stays on the Discharge Lounge													
		Actual	336	299	307	322	322	352	392	358	274	359	272	271

Improvement outcomes

- Improvement in both 12 and 4-hour performance in March 2025 following March Sprint focus.
    - 12 hour: 19.83%
    - 4 hour: 64.09%.

- Review of March Sprint interventions has been completed. Clinical progress chaser and clinical support of validation identified as two main contributors to improvement.
- Initial Lenth of Stay Planning Workshop held 19 March 2025. Plan to next present to the Executive Team on 17 April 2025.
- Highest total assessment area activity this year seen in March 2025.
- Consistently meeting 80% Virtual Ward (VW) capacity target. VW Finance Meeting took place to explore reducing cost per bed and introducing shared resource where appropriate.
- Relaunch of continuous flow. Close tracking of data to be monitored.
- Increase in percentage and number of weekend discharges seen for non-elective.
- OPSSU (Older Persons Short Stay Unit) audit completed- significant opportunity to reduce length of stay identified.
- OPSSU SOP has been developed and is ready to circulate for sign off.
- Review of Inpatient echo being conducted. Audit completed to highlight significant inappropriate referrals.

Key Learning

- Learn from what worked well during March sprint to implement as BAU (business as usual) to support ambition of 68.85% in April including clinical progress chaser and most robust and standardised validation process with clinical input where possible. Work with Trust wide stakeholders on CT and specialty in reach delays.
- Visit to Aintree Hospital to observe and gain learning of their MTS (Manchester Triage Score) process postponed due to operational issues.
- Progress with OPSSU planning and sign off PID (project initiation document). A provisional date of May 2025 for go live.
- Proposal for future of The Emergency Assessment Unit (EAU) to be discussed with the Unplanned Care Triumvirate to inform next steps.
- Resetting and agreement of Unplanned Care's improvement plans for 2025/26. 3 main areas will be NEL (non-elective stay). Length of stay, Frailty and 4-hour performance.
- MaDE event commenced on the 14th April 2025.
- SDEC (Same Day Emergency Care) NWAS (Northwest Ambulance Service) direct referral planned for Q1 2025/26. Pathways and next steps are currently being planned.

Objective 2:

Have all measures/monitoring been achieved.

Benefit Description	Metric Description	Baseline		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Capped Theatre Utilisation	Maximise theatre sessions to ensure all specialities are delivering 85% or greater than	71.4%	Target Equal to or greater than	72.63%	73.25%	73.56%	74.49%	75.73%	76.96%	78.2%	79.4%	80.67%	81.91 %	83.45%	85%
			Actual	72%	73.9%	74%	71.8%	77%	75.1%	75.7%	76.5%	76.7%	75.8%	74.2%	75.8%
Uncapped Utilisation (BI Dashboard)	Please note this is a redundant metric on MH		Actual	77.1%	79.7%	80.3%	78.6%	79.1%	80%	79.3%	83.3%	81.3%	80.4%	78.4%	81.3%
Reduction on the day cancellations to no more than 50 operations per month (Data Taken from internal dashboard final monthly position)	Will improve theatre utilisation and improve elective recovery position	23/24: 864 24/25: Max of 605	Target	64	57	50	50	50	50	50	50	50	50	50	50
			Actual	64	60	62	89	87	81	71	49	73	88	66	89
6.5% of on the day cancellation target		Percentage on the day cancellation	Target	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%
			Actual	6.83%	6.18%	7.16%	8.64%	10.16%	9.19%	7.69%	6.21%	9.1%	9.63%	7.79%	7.14%
%of planned time in elective sessions lost due to late starts (Data taken from last reporting week on model hospital)	Target Lowest Quartile 1 Model Hospital average 4% per	9.4%	Target Equal to or less than	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%
			Actual	9.4%	9.4%	9.0%	11.4%	7.9%	10.6%	8.6%	8%	8.2%	10%	11.4%	13.9%
Average late starts of 28 minutes or less than utilisation (Data taken from last reporting week on model hospital)	Theatres starting on time will minimise on the day cancellations thus improving theatre utilisation	36 minutes	Target	36	35	34	34	34	32	32	32	30	30	30	28
			Actual	36	41	30	31	31	29	35	25	26	33	38	46
Average inter-case down time by minutes ((Data taken from last reporting week on model hospital)	Target Lowest Quartile 1 Model Hospital average 10 minutes		Target	10	10	10	10	10	10	10	10	10	10	10	10
			Actual	16	17	18	17	19	15	16	13	12	14	13	12
Theatre capacity to deliver job plan sessions	To ensure theatre capacity is maximised to deliver job planned sessions	>405 (85%) of 477 Job plans (excluding on call)	Target	391	391	391	391	391	391	432	432	432	405	405	405
			Job plans delivered	338	428	410	396	350	378	362	317	298	358	286	330
Increase procedures per session C&M Dashboard (Target benchmarked against peer's average)	Maximising cases per session with increased utilisation and reduce wait times	2.13 cases per session	Target	2.13	2.18	2.25	2.25	2.25	2.40	2.40	2.40	2.60	2.60	2.60	2.80
			Actual	2.13	2.26	2.17	2.43	2.31	2.40	2.2	2.5	2.7	2.3	2.2	2.3

Improvement outcomes

Activity/Performance/Delivery Update

- Data Validation. Weekly validation Utilisation commenced.
- Forward Wait Test of Change - Relaunch April.
- QR Code Questionnaires & CSTM (Captain Sir Tom Moore) Ward and Day Case Ward Processes - Meeting scheduled 2 May 2025 with Nursing Team to discuss action plans for Ward Improvement Working Group.
- On-the-Day Cancellations - Slight incline to 69.

Optimising Theatre Efficiency and Maximising Activity

- Preop - Review of nurse pre-op slots complete, identifying an opportunity to increase nurse pre-op slots by 16% per week.
- FDP (Federated Data Platform) -Gone-live with Theatre Session Management, week commencing 24 March 2025. Training for Patient and Booking Management Pilot Group completed and Training for PBM (patient booking management) for other Waiting List Teams 75% completed.

Reducing Acuity of Care

- Day Case Arthroplasty - Virtual and face to face meeting completed with GIRFT regarding reducing length of stay of both knee and hip arthroplasty. All relevant areas represented by WHH.
- HVLC (high volume low complexity) Cataracts - Key Milestones and draft action plan compete (some actions in progress prior to Task & Finish Group established)
- Delivery of 4 Joints - Key milestones and draft action plan completed with a proposed go live date from October 2025.

Key Learning

Activity/Performance/Delivery Update

- Forward Wait – Report output from relaunch following lessons learned. Plan to implement the "Golden Patient" initiative is underway to reduce list order changes that impact timely starts with plans to commence with Urology and Trauma & Orthopaedics (May 2025)
- Meeting with WWL - Share learning via Ward Improvement Meeting planned 2 May 2025.
- QR Code Feedback – "You Said, We Did" planned for May 2025 - Deep Dive into Urology Capped Utilisation.

Optimising Theatre Efficiency and Maximising Activity

- Preop - Service review to begin. TOC aiming to increase slot capacity by 16%, to be confirmed.
- FDP - Continue with training for PBM users. Start PBM users completing actions in FDP prior to phased go-live with PBM 14/04/25. Explore and correct low booked utilisation figures.

Reducing Acuity of Care

- Day Case Arthroplasty - Working Group Meeting restarted with representation from all key areas as recommended by GIRFT. (April)
- HVLC Cataracts - Confirm Clinical lead to drive project and set up Task & Finish Group (April)
- Delivery of 4 Joints - Confirm clinical lead to drive project and set up task and finish group (April) and refine action plan and milestones with The Clinical Lead.

Objective 3:

Have all measures/monitoring been achieved.

Benefit Description	Metric Description	Baseline (April 2024)		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Clinic Utilisation	Maximised booking of all clinic slots to ensure full utilisation of available slots	70.19%	Target	64.34%	66.7%	69.0%	71.3%	73.7%	76.0%	78.3%	80.7%	83.0%	85.3%	87.6%	90.0%
			Actual	64.34%	64.5%	71%	77.4%	78.3%	79.6%	80.7%	81.5%	82%	82%	83%	83%
DNA	Reduction in the number of 'Did Not Attends' of patients to both new and follow up outpatient appointments.	7.85%	Target	7.85%	7.67%	7.49%	7.26%	7.03%	6.79%	6.55%	6.31%	6.08%	5.84%	5.67%	5%
			Actual	7.85%	7.29%	8.01%	7.85%	7.8%	7.7%	7.9%	7.8%	8.78%	8.52%	7.5%	7.76%
Short notice cancellations	Reduction in the number of less than 6-week clinic cancellations taking place by the Hospital.	7.78%	Target	7.78%	7.66%	7.55%	7.37%	7.19%	7.01%	6.83%	6.66%	6.48%	6.30%	6.15%	6%
			Actual	7.78%	6.64%	6.71%	6.36%	6.09%	5.94%	6.08%	5.5%	5.92%	6.93%	7.4%	6.95%
PIFU	Increased use of patient initiated follow ups. Metric captures Additions to PIFU access plan as % of Outpatient Attendances	3.20%	Target	3.20%	3.33%	3.46%	3.63%	3.81%	3.99%	4.18%	4.36%	4.54%	4.72%	4.86%	5.00%
			Actual	3.2%	3.39%	3.74%	3.77%	3.99%	4.25%	3.94%	4.4%	4.5%	4%	4.1%	4.6%
New to Follow up Ratio	The ratio of new appointments to follow up appointments per patient.	2.55	Target	2.66	2.65	2.64	2.63	2.62	2.61	2.60	2.59	2.58	2.57	2.56	2.55
			Actual	2.66	2.92	2.73	2.85	2.83	2.78	2.83	2.66	2.74	2.95	2.93	2.82

Improvement outcomes

Change of Consultant

- SOP written awaiting sign off at time of reporting.
- Training to commence with Outpatient Central Booking Team first before wider roll out to all Outpatient Booking Teams.

Clinic Templates

- Mapping complete for Diabetes, Endocrinology and ENT (Ear, Nose and Throat).
- Full overview of current service including template variances, new and follow up backlogs, New: follow up ratio, patient initiated follow up, did not attend (DNA), OPPROC (outpatient procedure) /day case and Virtual usage presented to Diabetes and Endocrinology Consultants and Nurse Consultant.
- Shadowing of clinics taken place to understand in more detail around practical constraints of timing of slots.
- Agreed with Consultants to have standardised templates of 6 new patients or 8 follow up patients per PA – 4 hours - for both specialities.
- Initial agreement to increase diabetes follow up slots by 116/year as per above.

Key Learning

Pre-Op

- Agreement from Commissioners that this change can commence from 1 April 2025, however, would require a financial adjustment to ensure it is cost neutral in 2025/26.
- This would benefit the Trust financially from 1 April 2026.
- This would improve the new to follow up ratio in 2025/26.
- Commissioners have agreed that if the Trust underperforms against the cap in 2025/26 the financial adjustment could be reversed to secure income.

IBD Advice Line

- Commissioners agreed we could start recording this activity from 1 April 2025 as this is follow ups and within fixed element of the contract, therefore is financially neutral.
- The income could then flow from 1 April 2026 subject to rebasing of the fixed contract.

Clinic Templates

- Further areas of review identified including review of antenatal pathway, activity being done not currently captured, clinics that fall outside of ‘standard templates’- meeting with Associate Medical Director required.
- Meeting with ENT Clinical and Operational Team to present findings.

• Roll out plan for specialties (1 per month) - Urology, Ophthalmology, Trauma & Orthopaedics, Rheumatology.

Has this Priority been achieved	Actions being taken
Partially	Although the Trust is currently partially achieving this priority, progress is being made through several pieces of work to make further improvements with an aim to fully achieve this priority.

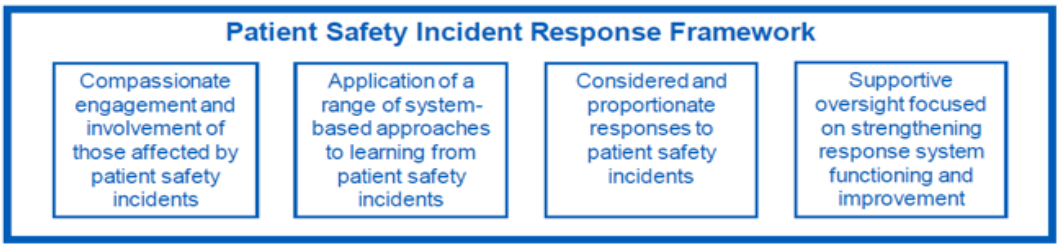
6. Continue to embed Patient Safety Incident Response Framework by developing and maintaining effective systems and responses for responding to patient safety incidents across the Trust.

Lead: Tracy Fennell, Deputy Chief Nurse/Director of Governance/Nicola Edmondson, Associate Director of Governance/Cathy Umbers, Deputy Director of Governance/Ernesto Quider, Associate Director of Quality/Adam Harrison-Moran, Head of Culture and Inclusion/Dr Eshita Hasan, Deputy Medical Director/Dr Lalitha Chinnappan, Associate Medical Director for Patient Safety

What success will look like

1. Ensure a patient safety culture continues to be embedded in accordance with the requirements of the Patient Safety Strategy and the implementation of the nationally mandated Patient Safety Incident Response Framework. Evidenced using incident reporting, learning responses and actions, risk management and triangulation of clinical governance will be evidenced through richer learning via new investigation methods including cluster reviews.

Q4 progress/summary



- The Patient Safety Syllabus Training is available to staff via the ESR platform and is mandated for staff who have been assessed as part of the Training Needs Analysis. Compliance is currently Level 1 at 97%, Level 2 at 86% and Senior Leaders at 94%.
- 64 staff have completed HSIB Systems Approach to learning from patient safety incidents training.
- 11 staff have completed the Gateway Training & Consultancy Ltd, Systems Based Approach to learning from patient Safety incidents.

Learning and Improvement
Continue to monitor training figures and support CBU's with investigation methodologies.

The Patient Safety Incident Response Policy and Plan had estimated refresh dates of March and September 2025.The incident profile has been reviewed and remained significantly unchanged.

It was agreed at the Executive PSIRF Meeting in November 2024 for priorities to remain unchanged for a further eighteen months and this will then be reviewed. The 3 local priorities which will be investigated using PSII methodology are:

- Missed or delayed diagnosis of a cancer
- Delay in the identification, recognition and response to a patient's deterioration resulting in delayed escalation and treatment.
- Delay in risk assessment and or management of a patient resulting in delayed treatment (with underlying Mental Health concerns)

The Patient Safety Incident Response Framework Policy and Plan have been revised to include additional sections on roles and responsibilities and timeframes for investigation and completion in line with national standards. Revisions also include a Training Needs Analysis, the new meeting /assurance structures and the bimonthly Executive Led PSIRF Group

The revised Policy and Plan were signed off at the Executive PSIRF Meeting in March 2025, and were ratified at the Trusts Policy Review Group in April 2025.

- A further 15 staff are booked to attend the Gateway Training & Consultancy Ltd, Systems Based Approach to learning from patient Safety incidents in May 2025.
- Additional Oversight Training will be delivered by Gateway Training & Consultancy Ltd- (A Systems Approach to Learning from Patient Safety Incidents), during 2025, to further support leadership roles in safety, dates are currently being finalised.
- Training for Ensuring, Patient, Family and Staff Involvement in Learning from Patient Safety Incidents for 12 staff will be provided by Gateway Training & Consultancy Ltd in June 2025.
- Two Patient Safety Partners are in post.
- 4 Patient Safety Specialists within the organisation have undertaken the level 3 and 4 Patient Safety Training Syllabus, with Loughborough University. Funding has been agreed for a further 5 members of staff to undertake this training during 2025.
- Mersey Internal Audit (MIAA) have concluded an audit on PSIRF, the report has noted a substantive level of assurance for PSIRF.

- A questionnaire had been developed and shared across the Trust to enable an evaluation of incident reporting. Questionnaire feedback was collated during Q4.

Datix Satisfaction Survey Report

The Datix Satisfaction Survey was circulated between during February and March 2025. Completion of the survey was promoted via Trust Wide Communications and directly to Datix users through the Datix Risk Management System platform.
40 members of staff completed the survey. Responses have been collated and themed to support analysis and development of action planning and improvement work.

System Complexity

- Users find there are too many boxes, questions, categories, and drop-down menus, contributing significantly to the complexity.
- The layout and interface design are unintuitive.
- There is difficulty distinguishing between mandatory and optional fields.

Time needed to fill out reports.

- The incident reporting process is described as too long, lengthy, and highly time-consuming.
- The need for repetitive data entry (personal/work details).
- The time and effort required are seen as a deterrent to staff reporting incidents.
- Frustration during the submission process, involving attempting submission, identifying errors, and making corrections.
- Specific features or option boxes within the forms are reported to slow down the completion process.

System Performance Issues

- The system frequently times out, often causing users to lose unsaved work.
- General instability is reported, including bugs (like forms jumping around during input).
- System performance is considered slow, particularly regarding loading times.

Content, Structure & Navigation Challenges

- Drop-down menus and the overall information structure are confusing and difficult to use effectively.
- Poor categorisation and an excessive number of options make selecting the correct category challenging.

- Necessary options (e.g. relevant categories) are sometimes missing from lists, hindering accurate reporting.
- Assigning reports to the correct person/department/CBU is difficult without specific prior knowledge.
- Users struggle with navigation for tasks such as logging back in to update incidents, finding specific reports (especially those filed by others or needing updates), and searching for historical events.
- Basic search functionality has usability issues (e.g., requiring scrolling and clicking 'search' instead of using the Enter key).

Feedback

- reporters frequently receive no feedback or communication about the outcome of their submitted incidents.
- Managing follow-up actions within the system (such as responding to messages, chasing outcomes, or viewing outstanding tasks related to a report)

Conclusion

The feedback received regarding the increased length of the incident reporting form and the time required for completion is something that the Trust are aware of. Many of these changes, particularly the increase in mandatory fields, are a direct result of aligning our system with the requirements of LFPSE (Learn from Patient Safety Events), the mandatory national system for recording and learning from incidents in the NHS. LFPSE necessitates the collection of specific, standardised data points to enable meaningful analysis. Whilst this unfortunately means a longer reporting process locally, the benefit is the ability to identify widespread safety trends, understand contributing factors more deeply, and implement evidence-based improvements that enhance patient safety both nationally and within our own Trust. Fulfilling these LFPSE requirements is mandatory for contributing to this national learning culture.

This feedback is not isolated to the Trust, as it mirrors that from other organisations. Whilst LFPSE is still in the early stages, the Trust hopes for improvement over time as the system and processes matures.

User feedback highlighted a concern regarding reporters not receiving updates or outcomes after submitting an incident report. System changes will be implemented by the beginning of Q2, in direct response to these comments. These modifications will ensure that feedback, updates, and final outcomes concerning submitted incidents are communicated directly back to the original reporter. This action aims to enhance transparency and better acknowledge the valuable contribution of staff who report safety events.

Concerns were raised in the feedback regarding the complexity of the incident categorisation structure within the Datix. Users reported difficulties in selecting appropriate options from the available categories and subcategories. A thorough review of the current incident categorisation will be undertaken by Q3. The objective of this review is to simplify the structure where possible, improve the clarity and logic of the categories presented, and ultimately make it easier and more intuitive for users to classify incidents accurately.

To address the issue of repeatedly entering reporter information when submitting incidents, the feasibility of enabling users to complete incident forms whilst logged into the system is currently being reviewed. By enabling users to fill out incident forms when logged in to the Datix system they would not have to fill out the reporter details section, this would automatically be populated. This is currently undergoing testing in the test environment to ensure that there are no adverse impacts on system performance or data integrity before implementation, prior to be launched by the end of Q1.

There have been reports of the system 'timing out.' There is currently no time out period set within the Datix system itself, however the design of the Edge internet browser will put inactive tabs in a 'sleep mode' which can cause Datix to time out. If the reporting form has been actively used, there should be no time out.
It has been identified that there is a 'bug' In Datix where the form appears to jump or scroll up and down. This is because of the auto population feature set in Datix. Datix are aware of this design issue.

Further to completion of the above identified actions, a further Datix Satisfaction Survey will be undertaken (during Q4), to support evaluations of improvement.

- WHH continues to participate with PLACE and Integrated Care Board (ICB) partners across Cheshire and Mersey to share learning to further support embedding of PSIRF and Learning from Patient Safety Events (LFPSE).
- An evaluation of Datix drop-in sessions was undertaken during Q3. Datix drop-in sessions will be replaced with a rolling Programme on various workstreams across the governance portfolio, including incident reporting and management. This will commence in Q1.
- Formal monitoring mechanism (to ensure that Engagement leads, and Learning response leads contribute to 2 or more responses per year) being developed and will be in place by the end of Q2.

Has this priority been achieved	Actions
Yes	This priority is currently being achieved.

Patient Experience

Patient Experience: By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.
7. Ensure that there are robust frameworks in place to care for patients with mental health challenges, evidenced through the implementation of a training package for nursing and medical staff and 95% compliance with the completion of Mental Health Act assessment and detention documentation **Leads**: Carol McEvoy, Associate Chief Nurse for Unplanned Care/Dr Jane Lang, Mental Health Lead and Emergency Care Consultant
What success will look like
1. Staff have the knowledge, skills and competency to ensure that the correct processes are followed during the assessment and/or detention of a patient under the Mental Health Act 2. Embed a robust process for ensuring that Mental Health Act paperwork is reviewed and signed for by an appropriate member of WHH staff, as delegated by the Trust Board of Directors. 3. Embed escalation processes to ensure correct receipt of section 17 leave paperwork when a patient attend/is admitted to WHH.
Q4 progress/ summary
Objective 1 **Have all measures/monitoring been achieved.** • During Quarter 4, discussions took place to provide further training sessions via the Mental Health Law Admin Team monthly sessions have been implemented over the last couple of months. Training has been completed with 56 staff. • A rolling Programme is currently being planned, and the Associate Chief Nurse of Unplanned Care continues to work with the Mental Health Law Administrator and have scheduled monthly teaching sessions across the Trust. • Evaluation of this has been undertaken. Increased training needs have been identified following the CQC 2021 visits to 100 NHS Hospitals. The Associate Chief Nurse of Unplanned Care and the Deputy Chief Nurse/Director of Governance/Director of Governance are currently reviewing the Trust Mental

Health Strategy. Current Mental Capacity Act training is above Trust target of 85% and stands at 97.59%.

- Flow charts have been uploaded to the Mental Health workspace on the intranet for staff to reference and provide support.
- Ward A8 and A9 continues to accommodate those patients who have complicated Mental Health issues, with the support of Core 24 and the Mental Health Team.

Improvement outcomes

- Compliance with Mental Health Act legal processes as measured by the compliance report produced by the Mental Health Law Admin Team.
- Feedback has been received from the Mental Health Law Admin Team that they have observed an improvement in compliance since the training has commenced via verbal feedback received from staff.

Key Learning

- Staff have expressed their appreciation for the training and that it keeps them informed of any changes that may occur. This feedback has been received verbally.
- There has been an increase in Mental Capacity Act (MCA) training.
- There are now relationships and communication between the Mental Health Law Admin Team and the workers. The team has benefited from this, and good working relationships have been established.

Objective 2

Have all measures/monitoring been achieved.

- A scoping exercise has been undertaken to review the delegation of authority of the Trust Board of Directors.
- Next steps involve a review of the options and agreement from the Executive Team regarding delegation of authority.
- The ED is conducting a scoping exercise to examine having a Core 24 employee available when triaging mental health patients at the front door who could need assistance but might not need admission or additional assessment.

Improvement outcomes

- Monitoring the compliance with Mental Health Law Processes.

Key Learning

- The Mental Health Act 1983 (as amended) places a number of legal duties upon Hospital Managers (meaning 'the Trust Board of Directors as a corporate body). However, on a day-to-day basis these duties are carried out by staff of the hospital. To be clear about who within the organisation is approved to discharge what duty on behalf of Hospital Managers, the Mental Health Act Code of Practice states that a Scheme of Delegation should be established and "approved by a resolution of the body itself"

Objective 3

Have all measures/monitoring been achieved.

- The Mental Health Law Administration Team conducted one training session in Q3. According to the Service Level Agreement (SLA), the Mental Health Law Admin Team is not in charge of managing section 17 leave documentation; nonetheless, the training does address the significance of receiving section 17 leave documentation.
- A "Section 17 notification" in a hospital refers to a formal notice informing staff that a detained patient is being granted "Section 17 leave," which means they are allowed to temporarily leave the hospital under the Mental Health Act 1983, with specific conditions and the ability to be recalled if necessary; essentially, it's a notification that a patient is being given authorised temporary leave from the hospital.
- Due to the positive feedback received from the Section 17 in-person training, a rolling program is being established. Staff members have embraced the input as encouraging, instructive, and allowing for candid and open discussions.

Improvement outcomes

- Increase in the compliance with receiving section 17 leave paperwork.

Key Learning

- Following on from the training there has been an Increased awareness and understanding of the necessity of obtaining section 17 leave documentation.

Has this Priority been achieved	Actions being taken
Yes	This priority is currently being achieved.

8. Reduce internal Hospital delays related to discharge planning to support safe and effective discharge, this will be evidenced through a reduction in failed discharges and a reduction in patients with 'no criteria to reside' (NCTR) averaged over 12 months

Leads: Zoe Harris, Director of Operations and performance, Deputy Chief Operating Officer/Sharon Kilkenny, Associate Director of Unplanned Care/Sarah Howarth Associate Director of Integrated Care

What success will look like

The targets are being developed through the Task and Finish Group in Urgent and Emergency Care and will be finalised in Q2.

1. Overall, Trust NCTR reduces to 15%
2. Increased number of patients discharged on Pathway 0 and Pathway 1
3. Reduced number of failed discharges due to internal delays, e.g. To Take Out's, Transport, missed cut of times for care home
4. Improved patient satisfaction
5. Increased number of discharges before 12 noon

Q4 progress/summary

Objective 1:

Have all measures/monitoring been achieved.

- New metrics were developed in Q1 and have been routinely reported through the UEC Programme.

Improvement outcomes

- The new metrics break down the discharge pathways 1/2/3 by length of stay post criteria to reside. Whilst the metrics have supported more targeted work to take place, the overall position has not improved.

Key Learning

- The breakdown of NRTR (no criteria to reside) by pathway shows a deteriorating position over the winter period across all pathways, for Warrington, Halton and OOA. The breakdown by pathway has supported a greater understanding of where blockages and delays are taking place. This information is being utilised to develop a refreshed action plan for 2025/26.

Objective 2:

Have all measures/monitoring been achieved.

- The CDC form was piloted and evaluated in Q3. The aim of this work was to shift the Discharge to Assess form onto Lorenzo rather than through email. The pilot was not successful, the system did not pull through all the data required so the original email process had to be continued. Further work has taken place during Q4 to address the issues found during the pilot phase, this work is still ongoing and will be implemented for testing again in Q1 2025/26.

Improvement outcomes

- The aim of this change is to enable more effective monitoring of when patients are declared medically ready for discharge and referrals being made to the Integrated Discharge Team, the timeline for discharge process and final discharge date. It is expected this will improve the accuracy of reporting for NRTR.

Key Learning

- As part of the pilot, some errors were identified with regards to the pull through of updated patient information to populate the Discharge to Assess (D2A) Form. The second round of the pilot will pick up these issues.

Objective 3:

Have all measures/monitoring been achieved.

- Transfer of Care Hub (TOCH) Nurses were embedded across 5 wards. (1 Whole Time Equivalent is still vacant due to recruitment freeze).

Improvement outcomes

- Support was provided to 5 in-patient wards (A7, K25, C21, A9, A6), a measurable improvement in the number of discharges, length of stay and the percentage of no criteria to reside was seen in these areas, whilst the wards without continued to have high rates in both internal and external discharge delays.
- The TOCH Nurse model has been reviewed with the aim of supporting a larger number of wards. This is being enabled through reviewing the roles of the Nurses, Discharge Facilitators and Social Workers in the TOCH. Phase 1 of the new model implemented support to The Emergency Department (ED) and assessment areas, the piloted started 3 February 2025. Phase 2 of the pilot rolled out from 3 March 2025 providing support across 15 wards.

Key Learning

- The new model is currently being monitored, phase 1 (support into ED and assessment areas) will be evaluated in Q1 2025/26, with phase 2 evaluation being completed in Q2 2025/26.

Has this Priority been achieved	Actions being taken
No	The Trust is not currently achieving this priority. However, the improvement work continues with the new metrics.

9. Improve the compliance with the Nutritional Assessment of Adult inpatients utilising the Malnutrition Universal Screening Tool (MUST). The overall target of the Trust is to achieve 95% compliance with assessment being completed within 24 hours of admission and then as a minimum every 7 days during their inpatient stay. With an aim to improve on current compliance in both metrics by 25% this year and to provide assurance that the appropriate level of intervention is provided to support patients in relation to their assessed needs and improve clinical outcomes.

Leads: Tracy Fennell, Deputy Chief Nurse/Director of Governance
Lucy Parry, Lead Nurse for Digestive Diseases/Deb Howard, Associate Chief Nurse for Corporate Services

What success will look like

1. A significant improvement in the compliance data in all 3 metrics by at least 25% by end of Q4.
2. Assurance that the correct actions/interventions are completed for patients identified as requiring support about nutrition.

Q4 progress/summary

Objective 1:

Have all measures / monitoring been achieved.

- MUST compliance in the 7-day assessment metric has remained static in Quarter 4 and we failed to meet the target of a 25% increase. An increase by 20.3% was achieved in the metric over the course of the year a shortfall from target of 4.7%.
- The 6-hour assessment and 24-hour assessments did not meet the target by a significant margin with less than 5% improvements being seen in either metric over the year. With a decline in improvements made in Q1 over the final 2 Quarters.

Improvement outcomes

Metric	Jan %	Feb %	March %	Improvement % for Quarter 4	Improvement For year %	RAG (achieving 25% improvement in compliance)
6-hour assessment	**41.47**	**40.88**	**40.86**	**-0.61**	**(**April 24 37.76) **= 3.1%**	
24-hour assessment	**62.90**	**62.99**	**66.84**	**3.94**	(April 24 61.97) = **4.87%**	
7-day assessment	**43.11**	**46.70**	**48.67**	**5.56**	(April 2428.37%) **= 20.3%**	

Key Learning

- The clinical indicators tab on Lorenzo does now turn amber prior to red to warn staff that MUST needs to be completed rather than indicating Green (Not due) RED (Overdue).
  Despite this being welcomed by Ward Teams there has been no positive effect on the 6- & 24-hours metrics. In late Quarter 4 it has been noted that this indicator is unreliable, and this has been escalated to the Trust IT department to improve reliability.
- Targeted training has been offered and provided to areas with compliance significantly below the Trust average.
- Have linked in with the Patients Safety Partners in the Trust to gain a different perspective for improvement in compliance strategies.

Objective 2:

Have all measures / monitoring been achieved.

- As compliance remains low in the assessment metrics it is still not possible to provide full assurance that patients are supported as required for their nutritional needs whilst in the Trust. The Wards and departments in the Trust complete the monthly Quality Metrics Audit which provides a low level of assurance that the patients' needs are being met.

Improvement outcomes

- The Quality Metric scores for Nutrition and hydration remain high across the Trust. This includes specific questions regarding the 6 hourly assessments and the accuracy and response to these questions. The Quality Metrics score and the MUST dashboard data show significant discrepancies and therefore are not able to provide assurance in regard to the monitoring of our patients.

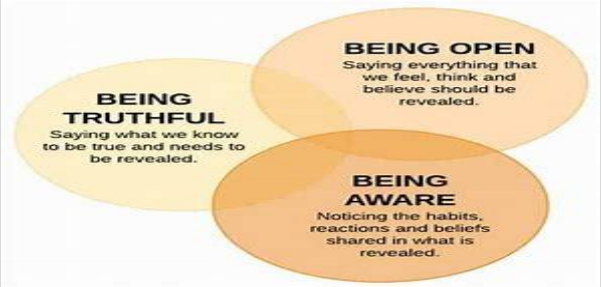
Key Learning

- To design and implement an audit to review interventions put in place to support patients' nutritional needs in greater detail than Quality Metrics currently provides.

Has this Priority been achieved	Actions being taken
No	This priority has not been achieved. An action plan has been developed to support in the improvements of MUST. See below: Quality Priorities Improvement Action

Metric – improve by 25%	RAG
MUST assessment within 6 hours	
Must assessment within 24hours	
Must assessment every 7 days	

Further to the agreed Quality Priorities 2024-25 Warrington and Halton Teaching Hospitals NHS Foundation Trust has also achieved a number of quality measures that evidence improvement across all three domains of quality. These include:



Statutory Duty of Candour Requirements

The Trust continues to consistently achieve 100% compliance in the notification of Duty of Candour both verbal and written (within 10 working days) following the occurrence of a notifiable patient safety incident.

Warrington named in Top 10 Trusts on National Maternity Survey

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) has once again been recognised for the high quality of its Maternity Services following publication of the 2024 CQC Maternity Survey.

Warrington and Halton Teaching Hospitals Dementia Team awarded for Outstanding Care

Warrington and Halton Teaching Hospitals' (WHH) dedicated Dementia Team received the 'Outstanding Dementia Care Team national award at the annual Dementia Care Awards.

New hub for Endoscopy Services Opens at Halton Hospital

A new £5 million Endoscopy Hub has officially opened in the Nightingale Building at Halton Hospital.

The hub, which is part of a wider Endoscopy Transformation Programme, will provide a modern

		space for diagnostics, surveillance and bowel cancer screening for patients across Cheshire and Merseyside.
		**New garden balcony to transform care for patients on Intensive Care Unit** A new garden balcony is set to be installed in 2025 to support patients on the Intensive Care Unit (ICU) at Warrington Hospital.
		Trust awarded for high-quality support of international nurses and midwives. Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) has received a prestigious NHS Pastoral Care Quality Award which recognises the exceptional support offered for internationally recruited nursing and midwifery colleagues.

2.2 Our Strategic Aims of Quality 2025-26.

In line with the vision for the future, the Trust has remaIned focused on the delivery of *Our Strategic Aim of Quality* which is linked to the achievement of the following 3 Strategic Objectives that are framed around the 3 quality domains of Patient Safety, Clinical Effectivness and Patient Experience:

- **Priority 1 - Patient Safety:** We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.
- **Priority 2 - Clinical Effectiveness:** We will ensure practice is based on evidence so that we do 'the right things in the right way to achieve the right outcomes' for our patients.
- **Priority 3 - Patient Experience:** We will place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

The Trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care using the following measures of success and all are supported by a separate group of indicators which are detailed further on.

- ✓ We will ensure every patient has the opportunity to feedback about their experience and we promise to use this to improve care and services.
- ✓ We will always put our patients first in everything we do, and we promise to communicate based on what matters most to you and in line with our values.
- ✓ We will ensure that we minimise harm for patients.
- ✓ Our patients should always experience care that is based on their specific needs, and we promise to work in partnership with you and your carers to achieve best possible outcomes.
- ✓ Every patient should experience care and treatment in the right environment, and we promise to continuously improve what you can see, do, hear and feel during your stay.
- ✓ Our processes should be designed to support our patients, and we promise to develop these so that everything is simple, done in a timely manner and easy to understand.
- ✓ We will be the best place to work and have safe systems of work in place.
- ✓ We will ensure partnership working and needs based care.

With the above measures of success in mind, the infographics below demonstrate our focused commitment to continually improve our services across the three domains of quality in 2025-26.

2.3 Looking Ahead – Our Quality Priorities 2024-25.

This section identifies:

- **How we have identified Our Quality Priorities for improvement with the involvement and engagement of our stakeholders**

Warrington and Halton Teaching Hospitals, NHS Foundation Trust has a duty to fully engage with stakeholders to ensure that priorities are both meaningful and focused, not only utilising internal intelligence but by hearing from a variety of groups that access our services. Feedback has been gathered throughout 2024/25 through engagement and discussion with the following:

- Non-Executive Directors/Executive Team.
- Governors.
- Patients and families.
- Experts by Experience.
- Staff.
- Staff Survey: Link https://cms.nhsstaffsurveys.reports/2023/RWW-benchmark-2023.pdf
- Integrated Care Board (PLACE presentation).
- Warrington Disability Partnership.
- Healthwatch.
- Patient experience and Inclusion Sub-Committee.
- Staying Connected Forum –distribution to Patients and Advocacy Groups.
- World Quality Day.

Learning from incidents, complaints, claims and risk has also been utilised to inform the proposed quality priorities 2025/26. The agreed Quality Priorities are outlined below. Progress

will be monitored through quarterly reports submitted to the Patient Safety and Clinical Effectiveness Sub Committee and to the Trusts Quality Assurance Committee, which in turn provides assurance to the Trust Board of Directors.

2025-26 Quality Priorities

Warrington and Halton Teaching Hospitals NHS Foundation Trust

The improvement aims	Description of Quality Priorities	The outcome
Improve patient safety	1. Ensure that all patients within the Emergency Department (UEC) receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes. 2. Improve access and productivity in elective care as per national operational planned guidance. 3. We will use quality improvement methods to improve provision of harm free care to our patients with a focus on preventing and reducing harms from pressure ulcers, malnutrition, and sepsis.	**Patient safety is enhanced through a learning culture where quality and safety is everyone's top priority**
Improve patient experience	4. Reduce Health Inequalities inline with CORE20+5 for Children, Adults and Young People. 5. Improve the experience and care provided for patients with a Learning Disability and impaired Mental Health. 6. Implementation of Accessible Information Standard relating to communication and reasonable adjustments to improve Patient Experience	**Practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients**
Improve clinical effectiveness	7. Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIFRT recommendations to support timelier and more effective patient care. 8. Reduce Cancer Waiting Times 9. Improve Theatre Safety Culture using whole quality system approach and robust governance process.	**The quality of the patient experience is at the heart of all we do and 'seeing the person in the patient' is the norm**

2.4 Statements of Assurance from the Board of Directors

The information in this section is mandatory text that all NHS Foundation Trusts must include in their Quality Account. We have added an explanation of the key terms and explanations, where applicable.

2.5 Information on the Review of services.

During 2024-25, the Warrington and Halton Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 6 relevant Health Services.

The Warrington and Halton Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 6 of these relevant Health Services (contracted services).

The income generated by the Health Services reviewed in 2024-25 represents 100% of the total income generated from the provision of relevant Health Services by the Warrington and Halton Teaching Hospitals NHS Foundation Trust for 2024/25.

2.6 Participation in National Clinical Audits and National Confidential Enquiries 2023-24.

What is a clinical audit: Clinical audit forms an integral part of the Clinical Governance Framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic measurement against explicit criteria and the implementation of any necessary change(s): New Principles of Best Practice in Clinical Audit, Healthcare Quality Improvement Partnership, 2nd Edition, 2011.

All NHS organisations are required to have in place a comprehensive Programme of quality improvement activities that includes healthcare professionals participating in regular clinical audit. Clinical audit is the governance vehicle in relation to determining assurance within clinical practice and is integral to the core business of the Trust.

The Clinical Audit Department is committed to raising the profile of clinical audit within the Trust recognising the importance of the annual forward audit plan and its contribution to improving patient outcomes and experience. The Trust-wide Forward Audit Plan 2024-54 was implemented at the start of the financial year following approval by the Patient Safety and Clinical Effectiveness Committee and by the Quality Assurance Committee.

On an annual basis, NHS England publishes a list of national clinical audits and clinical outcome review Programmes that it advises Trusts to prioritise for participation and inclusion in their Quality Account for that year. This will include projects that are ongoing alongside new items. NHS England Quality Accounts List 2024-25 has been confirmed and available from HQIP website via the following link: https://www.hqip.org.uk/wp-content/uploads/2024/01/20240129_NHSE-QA-List-2024-25_FINAL.pdf

The Trust is also committed to undertaking local clinical audits many of which focus upon some of the greatest challenges experienced by the population that we serve. The information below provides an overview of all the national clinical audits, confidential enquiries and local clinical audits undertaken during 2024-25.

2.6.1 Participation in Quality Account Clinical Audits 2023-24.

During 2024-25, 60 National Clinical Audits and 4 national confidential enquiries covered relevant Health Services that Warrington and Halton Teaching Hospitals NHS Foundation Trust provides.

During that period, Warrington and Halton Teaching Hospitals NHS Foundation Trust participated in:

- 98% of the national clinical audits.
- 100% of the national confidential enquiries of the national clinical audits.
- National confidential enquiries which it was eligible to participate in as detailed in the table below.

The table below shows:

1. The national clinical audits and national confidential enquires that Warrington and Halton Teaching Hospitals NHS Foundation Trust was eligible to participated in, for which data collection was completed during 2024-25, are listed below alongside the number of cases submitted to each audit or enquiry.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
1	**BAUS Data & Audit Programme**			
	a) BAUS Penile Fracture Audit	N/A		
	b) BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	N/A		
	c) Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes	Yes	7 cases submitted
2	**Breast and Cosmetic Implant Registry**	Yes	Yes	9 cases submitted, ongoing data submission.
3	**British Hernia Society Registry**	Yes	Yes	Consultants are currently still registering for this registry, which only opened in December 2024.
4	**Case Mix Programme (CMP)**	Yes	Yes	Intensive Care Unit April-September 2024 – data “clean” (submission and validation complete) and reported on 324 records. October-December 2024 – full submission and in validation 211 records.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				Ongoing data submission.
5	**Child Health Clinical Outcome Review Programme**	Yes	Yes	See table below with National Confidence Enquiry into Patient Outcome and Death Information.
6	**Cleft Registry and Audit Network (CRANE) Database**	N/A		
7	**Emergency Medicine QIPs**			
	a) Care of Older People	Yes	Yes	338 cases submitted, ongoing data submission.
	b) Mental Health (Self-Harm)	Yes	Yes	261 cases submitted, ongoing data submission.
	c) Time Critical Medications	Yes	Yes	108 cases submitted, ongoing data submission.
8	**Epilepsy 12 - National Clinical Audit of Seizures and Epilepsy for Children and Young People**	Yes	Yes	29 cases submitted, for cohort 6 (January to December 2024), ongoing data submission.
9	**Falls and Fragility Fracture Audit Programme:**			
	a) Fracture Liaison Service Database (FLS-DB)	N/A		
	b) National Audit of Inpatient Falls (NAIF)	Yes	Yes	8 cases submitted, ongoing data submission.
	c) National Hip Fracture Database (NHFD)	Yes	Yes	365 cases submitted, ongoing data submission.
10	**Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)**	Yes	Yes	11

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
11	**Maternal, Newborn and Infant Clinical Outcome Review Programme**	Yes	Yes	Multiple studies: MBRRACE-UK - Maternal Mortality – 2020 – 2022. 1 case
12	**Medical and Surgical Clinical Outcome Review Programme**	Yes	Yes	See table below with National Confidence Enquiry into Patient Outcome and Death Information.
13	**Mental Health Clinical Outcome Review Programme**	N/A		
14	**National Adult Diabetes Audit (NDA):**			
	a) National Diabetes Core Audit.	Yes	Yes	2420 cases submitted, ongoing data submission.
	b) Diabetes Prevention Programme (DPP) Audit	Yes	Yes	Information is drawn from the National Diabetes Audit. Ongoing data submission.
	c) National Diabetes Footcare Audit (NDFA)	Yes	Yes	66 cases submitted, ongoing data submission.
	d) National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	36 cases submitted, ongoing data submission.
	e) National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	25 cases submitted, ongoing data submission.
	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Yes	Any Paediatric or Adult Diabetes Services that participate in either the NPDA or NDA are automatically included. No additional data submission is needed.
	g) Gestational Diabetes Audit	Yes	Yes	Data collected directly from Maternity Services dataset (MSDS) –

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				Ongoing data collection – dashboard will be available late 2025.
15	**National Audit of Cardiac Rehabilitation**	Yes	Yes	193 cases submitted, ongoing data submission.
16	**National Audit of Cardiovascular Disease Prevention in Primary Care (CVD Prevent)**	N/A		
17	**National Audit of Care at the End of Life**	Yes	Yes	25 submitted, ongoing data submission.
18	**National Audit of Dementia (NAD)**	Yes	Yes	50 submitted, ongoing data submission.
19	**National Bariatric Surgery Registry**	N/A		
	National Cancer Audit Collaborating Centre (NATCAN)			
20	**National Audit of Metastatic Breast Cancer (NAoMe)**	Yes	Yes	These audits are now incorporated within the COSD monthly return, data not available at present.
21	**National Audit of Primary Breast Cancer (NAoPri)**	Yes	Yes	As above.
22	**National Bowel Cancer Audit (NBOCA)**	Yes	Yes	As above.
23	**National Kidney Cancer Audit (NKCA)**	Yes	Yes	As above.
24	**National Lung Cancer Audit (NLCA)**	Yes	Yes	As above.
25	**National Non-Hodgkin Lymphoma Audit (NNHLA)**	Yes	Yes	As above.
26	**National Oesophago-Gastric Cancer Audit (NOGCA)**	Yes	Yes	As above.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
27	**National Ovarian Cancer Audit (NOCA)**	Yes	Yes	As above.
28	**National Pancreatic Cancer Audit (NPaCA)**	Yes	Yes	As above.
29	**National Prostate Cancer Audit (NPCA)**	Yes	Yes	As above.
30	**National Cardiac Arrest Audit (NCAA)**	No	N/A	N/A
31	**National Cardiac Audit Programme (NCAP):**			
	a) National Adult Cardiac Surgery Audit (NACSA)	N/A		
	b) National Congenital Heart Disease Audit (NCHDA)	N/A		
	c) National Heart Failure Audit (NHFA)	Yes	Yes	566 cases submitted, ongoing data submission.
	d) National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	252 cases submitted, ongoing data submission.
	e) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	260 cases submitted, ongoing data submission.
	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	N/A		
	g) UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N/A		
	h) Left Atrial Appendage Occlusion (LAAO) Registry	N/A		
	i) Patent Foramen Ovale Closure (PFOC) Registry	N/A		
	j) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry2	N/A		
32	**National Child Mortality Database (NCMD)**	Yes	Yes	All deaths of children from the Warrington and Halton areas are discussed at the

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				CDOP (Child Death Overview Panel) and this feeds into the NCMD.
33	**National Clinical Audit of Psychosis (NCAP)**	N/A		
34	**National Comparative Audit of Blood Transfusion:**			
	a) National Comparative Audit of NICE Quality Standard QS138	Yes	Yes	32 cases – 100% of sample required.
	b) National Comparative Audit of Bedside Transfusion Practice	Yes	Yes	20 cases - 100% of sample required.
35	**National Early Inflammatory Arthritis Audit (NEIAA)**	Yes	Yes	6 cases submitted, ongoing data submission.
36	**National Emergency Laparotomy Audit (NELA)**			
	a) Laparotomy	Yes	Yes	91 cases submitted, ongoing data submission.
	b) No Laparotomy	Yes	Yes	5 cases submitted, ongoing data submission.
37	**National Joint Registry**	Yes	Yes	Latest published data: April 2022 – March 2023 The Cheshire & Merseyside Treatment Centre (CMTC) 473+ cases submitted, ongoing data submission.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				WHH 58+ cases submitted, ongoing data submission.
38	**National Major Trauma Registry**	Not live yet	N/A	This will be opened in a Programme of four phases: Phase 1: major trauma centres (adult and children) Phases 2 to 4: trauma units and participating local emergency hospitals.
39	**National Maternity and Perinatal Audit (NMPA)**	Yes	Yes	2018/19 data 2137 births, ongoing data submission.
40	**National Neonatal Audit Programme (NNAP)**	Yes	Yes	250 total neonatal admissions between April 2024 and 29th Jan 2025, ongoing data submission.
41	**National Obesity Audit (NOA)**	N/A		
42	**National Ophthalmology Database (NOD)**			
	a) Age-related Macular Degeneration Audit	Yes	Yes	1st January 2024 – 31st December 2024 893 patients. 1st January 2025 – 04/02/2025 442 patients. Ongoing data submission.
	b) Cataract Audit	Yes	Yes	Latest data reported. 1st April 2022 - 31st Mar 2023 621cataracts. Ongoing data submission.
43	**National Paediatric Diabetes Audit (NPDA)**	Yes	Yes	Latest data 1st April 2023 - 31st Mar 2024 156 cases.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				Ongoing data submissions.
44	**Perinatal Mortality Review Tool (PMRT)**	Yes	Yes	All live birth, up to 28 days of age. More than 22 weeks gestation and any still births are discussed and feed into the National PMRT database.
45	**National Pulmonary Hypertension Audit**	N/A		
46	**National Respiratory Audit Programme (NRAP)**			
	a) COPD Secondary Care	Yes	Yes	566 cases. Ongoing data submission.
	b) Pulmonary Rehabilitation	Yes	Yes	329 cases. Ongoing data submission.
	c) Adult Asthma Secondary Care	Yes	Yes	172 cases. Ongoing data submission.
	d) Children and Young People's Asthma Secondary Care	Yes	Yes	20 cases. Ongoing data submission. ongoing data submission.
47	**National Vascular Registry (NVR)**	N/A		
48	**Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)**	N/A		
49	**Paediatric Intensive Care Audit Network (PICANet)**	N/A		
50	**Perioperative Quality Improvement Programme**	N/A		
51	**Prescribing Observatory for Mental Health (POMH):**			
	a) Rapid tranquillisation in the context of the	N/A		

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
	pharmacological management of acutely disturbed behaviour			
	b) The use of melatonin	N/A		
	c) The use of opioids in Mental Health Services	N/A		
52	**Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)**	No	N/A	N/A
53	**Sentinel Stroke National Audit Programme (SSNAP)**	Yes	Yes	April-December 2024. 413 cases submitted, ongoing data submission.
54	**Serious Hazards of Transfusion UK National Haemovigilance Scheme**	Yes	Yes	8 cases submitted, ongoing data submission.
55	**Society for Acute Medicine Benchmarking Audit**	Yes	Yes	69 cases submitted.
56	**UK Cystic Fibrosis Registry**	Yes	Yes	25 cases submitted, ongoing data submission.
57	**UK Renal Registry Chronic Kidney Disease Audit**	Yes	Yes	Data submitted via Liverpool Royal Hospital. Latest figures 2021. Ongoing data collection: Transplant: 0 adult cases submitted. Haemodialysis: 5 adult cases submitted. Peritoneal Dialysis: 0 adult cases submitted.
58	**UK Renal Registry National Acute Kidney Injury Audit**	Yes	Yes	Latest data submitted to AKI Laboratory Portal in 2023-2024, AKI stages 1, number of AKI episodes:

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review Programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				Q4 (2023) 887 alerts submitted via laboratory (lab). Q1 (2024) 873 alerts submitted via lab. Q2 (2024) 783 alerts submitted via lab. Q3 (2024) 720 alerts submitted via lab. Ongoing data collection.

National Confidential Enquiries				
HQIP ID No.	**National Confidential Enquiries**	**Eligible**	**Participated**	**Number of cases submitted**
1.	ICU Rehabilitation	Yes	Yes	6 Clinician questionnaires and 1 Organisational Questionnaire were assigned. 6 clinician questionnaires and 1 organisational questionnaire have been submitted. **The report is yet to be published. Expected publication date: Spring 2025**
2.	Hypernatraemia	Yes	Yes	1 Clinician questionnaire and 1 organisational was assigned. Both the clinician and the organisational questionnaire was completed and submitted. **The report is yet to be published. Expected publication date: Winter 2025**
3.	Acute Limb Ischaemia Study	Yes	Yes	1 Organisational Questionnaire was assigned to the Trust and 1 request for patient records was received.

National Confidential Enquiries				
HQIP ID No.	**National Confidential Enquiries**	**Eligible**	**Participated**	**Number of cases submitted**
				Both the Organisational questionnaire and the patient records were completed and submitted. **The report is yet to be published. Expected publication date: November 2025**
4.	Emergency (non-elective procedures in children and young people: Transfer	Yes	Yes	2 Clinician questionnaires were assigned. 1 questionnaire has been completed. The remaining questionnaire has been removed from the system as the patient was not treated at Warrington and Halton Hospitals. **The report has is yet to be published. Expected publication date: Late 2025**
5.	Emergency (non-elective procedures in children and young people: Anaesthetic	Yes	Yes	7 Clinician questionnaires were assigned. 7 questionnaires have been completed and submitted. **The report has is yet to be published. Expected publication date: Late 2025**
6.	Emergency (non-elective procedures in children and young people: Surgical	Yes	Yes	7 Clinician questionnaires were assigned, and 1 Organisational Questionnaire was assigned. All 7 clinician questionnaires and 1 Organisational questionnaire has been completed and submitted. **The report has is yet to be published. Expected publication date: Late 2025**

National Confidential Enquiries				
HQIP ID No.	**National Confidential Enquiries**	**Eligible**	**Participated**	**Number of cases submitted**
7.	Hyponatraemia	Yes	Yes	6 Clinician questionnaires were assigned. All 6 questionnaires have been completed and submitted. **The report is yet to be published. Expected publication date: Winter 2025**

The reports of 17 national clinical audits were reviewed by the Trust in 2024-25, and Warrington and Halton Teaching Hospitals NHS Foundation Trust are taking the following actions to improve the quality of healthcare provided:

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
1.	National Sentinel Stroke Audit (SSNAP) 1st April 2022 - 31st March 2023	The Trust latest figures (Quarter 4 2023/34) are demonstrating a score in band C. The SSNAP score is calculated from Key Indicator scores which are grouped into 10 domains. Actions: Decrease the number of directly admitted patients by ensuring that appropriate patients follow the correct stroke pathway. This will include setting up a monthly meeting with Whiston to review any patients directly admitted. Embed processes in place to enable data collection for the new dataset go live date.
2.	National Audit for Care at the End of Life (NACEL) Round 4 1st April 2022 - 22nd May 2022	There has been significant learning from this round of NACEL, much echoed by other internal evidence and local and national guidelines - this triangulation of evidence has led to the development of the 2023-2025 WHH Adult Palliative and End of Life Care Strategy and associated Key Performance Indicators and many of the planned improvements are already well underway. A robust WHH action accompanied is in place to enhance further improvements.
3.	National Respiratory Audit Programme	Improvements were seen since the last round of results. KPI 5 'Current smokers with tobacco dependency addressed' was 100%. NRAP has asked the Trust to

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
	(NRAP) Adult Asthma Audit 1st October 2022 - 31st March 2023	provide a case study to highlight good practice in both audit data collection and entry, and in provision of quality adult asthma care. **Action:** Improve Peak Expiratory Flow (PEF) measurement at arrival.
4	National Diabetes Audit (NDA) Core Annual 1st January 2022 - 31st March 2023	Year on year WHH data shows improvement in all areas despite acquiring additional 135 patients in 2022-2023. **Actions:** Check reasons for why patients are not seen including did not attend (DNA) and waiting lists. Engage with WHH information and data analysts to seek ways of improving quality of data submission. Liaise with path lab and OPD staff to improve urine albumin-to-creatinine ratio (uACR) monitoring.
5.	National Neonatal Audit Programme (NNAP) 1st January 2022 - 31st December 2022	The report highlighted some issues which are being managed by the Perinatal Optimisation Team. **Actions:** Improve the rates of antenatal steroid and magnesium delivery in women at high risk of delivering prematurely – staff training, monitoring of rates. Improve the rates of delayed cord clamping at delivery – staff training and awareness. Improve the rates of early colostrum – parent information, training of nursing and midwifery staff.
6.	Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme (CMP) 1st April 2022 - 31st March 2023	The report shows WHH as performing within range apart from the indictors related to 'bed days' and 'discharges direct to home'. **Actions:** Formalise discharge checklist for patients who are discharged to home. Formalise referral pathway to parent upon step-down decision made by ICU.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		Engagement of parent teams for regular review of patients once step-down from ICU made. Formalise Discharge Policy in consultation with bed management – where the number of level 1 patients allow (patients in which decision to step-down has already been made). 2 physical beds (out of 18 funded beds) should be made available for possible admissions.
7.	Diabetic Footcare Audit (NDFA) 1st April 2018 - 31st March 2023	85% of the metrics were positive (yes) responses. Where 'no' was answered, there are alternative arrangements in place for service provision. The only action focussed around increasing the data collection for the audit. **Action:** To encourage audit forms to be completed on all diabetic footcare clinic patients.
8.	National Pulmonary Rehabilitation audit (PR) 1st Oct 2022 - 31st March 2023	The Pulmonary Rehabilitation Team continue to work towards recovering the service following suspension of rehab during the covid pandemic and extensive backlog of patients. This has been further challenged by volume of new referrals, loss of venues for assessment, service redesign and staff shortages within the team. **Action:** Completion of a practice walk test with suitable patients.
9.	National Lung Cancer Audit (NLCA) 1st January 2022 - 31st December 2022	The audit highlighted data completeness issues, particularly with smoking status and Clinical Nure Specialist (CNS) involvement, affecting the accuracy of the audit results. **Actions.** Cancer data manager to undertake collaborative work with Public Health England (PHE)/ NLCA as well as Clatterbridge Cancer Centre (CCC) to understand and resolve data discrepancy issues relating to total patient numbers and the number seen by a CNS. CNS Team to update SOMERSET database in real time/as soon as possible after any patient contact to improve CNS seen metric. Lung Cancer Lead to collaborate with medical oncologist to understand and resolve barriers to improvement in Systemic Anti-Cancer Therapy (SACT) rates.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
10.	National Bowel Cancer Audit 1st April 2021 - 31st March 2022	This audit has maintained high assurance and has improved on a range of metrics since the last report on 2019-2020 data. **Action:** Modify a user-friendly enhanced recovery Programme which is likely to help improve patients experience and shorten length of stay.
11.	National Pregnancy in Diabetes Audit (NPID) 1st January 2020 - 31st December 2022	WHH have a higher than national rate of caesarean sections but no pre-term deliveries and a lower than national rate of admission to the neonatal unit (NNU). **Actions:** Design a new pre-conception leaflet for community. Appoint WHH Diabetes Midwife. Monthly local Multi-Disciplinary Team (MDT) to discuss patients with diabetes and raised HbA1c. Confirm funding mechanism for diabetes related technology. All staff providing diabetes care during pregnancy need to show accredited training around diabetes technology.
12.	National Audit of Dementia (NAD) – Timepoint 4 Patient Feedback Report 1st April 2024 - 30th September 2024	Most questionnaires submitted were completed by the person living with dementia (84%) and the other responses were completed by a family member of someone living with dementia (16%). Overall, the feedback received was reflective of a positive experience whilst in hospital for people living with dementia. **Action:** The Dementia Team to explore options such as using a 'hospital journey' document which could improve communication for those individuals who are experiencing short term memory issues but still wish to be updated of their care and treatment.
13.	National Emergency Laparotomy Audit (NELA) 9th Year 1st December 2021 - 31st March 2023	Improvements have been seen across several metrics and this audit was awarded the WHH Clinical Audit Award of Excellence. **Action:**

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		Recruitment of a geriatric physician to review elderly and frail NELA patients.
14.	National Audit of Cardiac Rehabilitation (NACR) 1st January 2022 - 31st December 2022	During this period of data collection, the Cardiac Rehabilitation Service continued with the service covid recovery plan. Subsequent data continues to show recovery and 'Green' accreditation. **Actions:** To continue with Covid Recovery Plan. To re-start exercise groups and education Programmes.
15.	Breast and Cosmetic Implant Registry (BCIR) 1st January 2022 - 31st December 2022	As a Breast Service WHH have been enrolled in the Breast and Cosmetic implant registry/audit for several years. **Action:** Send E-mail reminders to breast clinicians to remember to enrol breast implant patients in the registry and to complete forms in a timely manner.
16.	The National Diabetes Inpatient Safety Audit (NDISA) 1st June 2024 - 31st October 2024	From the audit, the following key learning emerged: The importance of tailored care for frail elderly patients who require less aggressive blood glucose control to avoid hypoglycaemia risks. **Action:** To develop a mandatory training 'safe use of insulin course' on the Electronic Staff Record (ESR).
17.	Epilepsy12 1st December 2020 - 30th November 2022	The main issue arising from this audit is that WHH do not have access to a psychologist in house – this is on the Psychology and Neurology Risk Register's, with a risk rating is 12. It important to recognise psychology support is provided via an externally contracted company. **Actions:** Improve communication and patient information regarding Sudden unexpected death in epilepsy (SUDEP). Increase Individual healthcare plans for all patients. Develop clinic letters to fulfil requirements as Care Plan (agreement).
18.	National Ophthalmology Database (NOD)	Posterior capsular rupture (PCR) is the most common complication during cataract surgery and if this happens there is an increased risk of post-operative complication.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
	1 April 2021 - 31 Mar 2022	WHH results – 99.22% completed without complication compared to 98.9% nationally. **Action:** No actions required as this audit provides assurance that delivery of NHS-funded treatment for cataracts is of good quality overall and within expected limits.
19.	National Joint Registry Warrington and Cheshire and Mersey Treatment Centre (CMTC) – separate reports for each centre 1 April 2022 - 31 March 2023 (some charts have extended timeframes)	Overall metrics are good and/or higher than expected (national figures). This signifies that joint replacements at WHH are highly successful operations that bring many patients improved mobility and relief from pain, enhancing the 'Patient Experience' for patients. **Actions:** No actions required. This national audit is to be considered for the Clinical Audit Award of Excellence as the NJR demonstrates high assurance over a number of years with consistent improvement being made in a number of metrics.

Local clinical audit is important in measuring and benchmarking clinical practice against agreed markers of good professional practice stimulating changes to improve practice and re-audit to determine that service improvements have been made and sustained.

The reports of 27 local clinical audits were reviewed by the Trust in 2024-25 with actions in progress to improve the quality of healthcare provided. The table below details a sample of local audits undertaken.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
	Clinical Support Services	
1.	Procedural Sedation and Analgesia in Interventional Radiology	This audit has shown continuous improvement, year on year, in preoperative assessment and capnography monitoring. **Actions:** Safety checklist to be used at start of procedure to prompt use of capnography monitoring with Anaesthetists. Sedation Lead for Anaesthetics to add action to Anaesthetics Team Meeting to remind Anaesthetists that

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		capnography monitoring should be used for all patients having sedation in Radiology. This audit has been awarded the 'Clinical Audit Award of Excellence'*.
2.	Re-Audit of treatment of Haemochromatosis patient to British Society of Haematology Guidelines	This audit showed improvement for patients with baseline ferritin > 1000 ug/l who have had a Fibro scan: In initial audit 2022 = 25% In Re-audit 2024 = 100% No action plan required. This audit has been awarded the 'Clinical Audit Award of Excellence'.
3.	Re-Audit of Interventional Radiology World Health Organisation (WHO) & Local Safety Standards for Invasive Procedures (LocSSIP) audit	There was an improved compliance with the results from the previous audit. However, there are still areas for improvement: **Actions:** Discuss all points raised at the Procedural Safety Steering Group (PSSG). This includes the completion of the safely checklist which should be scanned onto the Electronic Patient Record (EPR). Reminder to teams that they must not use abbreviations.
Corporate Services		
4.	Trustwide National Early Warning Score (NEWS2)	There has been a consistent improvement in the correct frequency selection, which shows an improved understanding and utilisation of the NEWS2 policy. Further work is needed to address the occasions where observations are not performed at least 12 hourly. **Actions:** Monthly local audits to be performed by all areas. These are for review and inclusion in local management plans led by matrons and overseen by lead nurses. Further NEWS 2 auditing training offered to Ward Managers, Matrons and delegated Band 6 to increase resilience to sickness/absence/personnel changes. All registered nurses using NEWS 2 to attend AIM (Acute Illness Management) training every 3 years.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Fraxinus to develop software enabling auto population of recommended frequency.
5.	Trust wide Enhanced Care Assessment	The audit found that some areas in the Trust are still using the old version of the enhanced care assessment tool. As the new tool was launched around 12 months ago, it was expected that all areas would be using the new tool (E-CAT). **Actions:** To ensure that all areas are using the new 'E-CAT' tool within the next 6 months. To complete a video to share with staff highlighting enhanced care from the patient's perspective.
6.	Trust wide Fluid Balance	The audit data demonstrates that there is improvement required in the accurate completion of the fluid balance chart including accumulative input and output and total output. **Actions:** Update Fluid Balance Guidelines with roles and responsibilities and single point lesson and re-launch. Confirm with clinical areas that continence pad weighting scales are available in the clinical area. Review and update Acute Kidney Injury (AKI) presentation in relation to fluid balance charts including responsibilities. Launch an education campaign promoting completion of fluid balance. Review the content currently delivered re fluid balance charts at Health Care Assistants (HCA) induction.
7.	Trust wide Falls	Overall, there have been improvements in the 2024 audit in comparison to 2023 audit. However, only 17% of all patients had a visual aid by the bedside to alert staff they need to be used/not used. This has now been implemented Trust wide. **Actions:** Complete audit of inpatient areas to ensure there are visual aids at the bedside to demonstrate use of bedrails. Ward walk-arounds to check falls alarms are working and dated from time they have been in use.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Amend Falls Policy to incorporate new bedside eyesight vison assessment and launch Trust wide. Complete thematic review of falls with moderate or severe harm.
	Digestive Diseases	
8.	Breast Imaging Guidelines Compliance Re-Audit	Once again, the results demonstrated that 100% of female patients under 40 received ultrasound scans, aligning with the guideline recommendations for early breast cancer detection in this age group. In contrast, 100% of female patients over 40 underwent mammograms unless they had received one in the past six months, in which case they were referred for ultrasound. No actions required 100% compliance (will continue to re-audit).
9.	Use of Intensive Care Unit (ICU) Handover Forms for Theatre Admissions to Critical Care	The Anaesthesia Clinical Services Accreditation (ACSA) standard refers to the presence of a formal document for handover which is now present. The next step is to increase its utilisation. **Action:** Attach the handover forms to pre-existing Local Safety Standards for Invasive Procedures (LocSSIP) documents for invasive line insertion as a prompt for clinicians to fill them in when admitting patients to ICU as these patients often require invasive lines.
10.	Management of Acute Cholecystitis – Re Audit	This re-audit demonstrates significant improvement with best practice compliance in comparison with previous cycle (from 22.39% to 61.68%). **Action:** To encourage early laparoscopic cholecystectomy, within 7 days, for patients admitted with acute calculous cholecystitis by all the on-call Consultants.
	Integrated Medicine & Community	
11.	Blood Glucose Monitoring in COVID-19 Patients Receiving Corticosteroid Treatment	This audit shows the significance of measuring blood glucose levels as per the guidelines for early detection and prompt management of diabetic complications. **Actions:** Include an update in the Trust wide Patient Safety Brief.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Add a poster in the ward to emphasize the importance of measuring blood glucose levels as per guidelines, in these patients. Include regular reminders at Ward Multi-disciplinary Team (MDT) Meetings and weekly A9 teaching sessions, to measure blood glucose levels as per guidelines, in these patients. Discuss at Clinical Business Unit Governance Meetings escalating to the Care Group Triumvirate by exception.
12.	Re-audit of Venous Thromboembolism (VTE) Prophylaxis in Stroke Patients	Overall, in comparison with the previous audit in year 2022-2023 there is a higher rate of compliance with the standards in the national guidelines for VTE prophylaxis against which Warrington and Halton Trust conducted a re-audit in 2023-2024. **Actions:** To continue to include Prevention of VTE regularly as a topic in ward induction. To permanently display the laminated posters of flow chart for VTE prophylaxis in stroke patients in Ward B14. To re-appoint a ward VTE champion.
13.	Re-audit of Corticosteroids Use in COVID-19 Patients Against NICE guidance	The 2 cycles of audit clearly states that we must follow the NICE and Trust guidelines while considering Corticosteroid in a COVID positive patients to prevent the adverse effects of steroids. **Action:** Highlight the NICE and Trust guidelines for the use of corticosteroid in a COVID positive patients in weekly ward rounds.
Medical Care		
14.	Insulin Incidents Affecting In-patients	During the audit period, May to August 2023, there were 12 insulin related incidents. **Actions:** Improve knowledge of diabetes management for nursing staff 1:1 after incident. Improve compliance of insulin safety mandatory training.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Share learning with senior managers regarding diabetes related incidents through medicine management reports.
15.	Audit to Review the Standards of Documentation Related to Intra-articular Injections and Aspirations in the Rheumatology Joint Injection Clinics	Variability noted between care providers was identified as a potential gap in care. Previous audit in 2023 showed 100% compliance with all the 3 standards. **Actions:** To provide an education session at the Rheumatology Audit Meeting on the importance of documentation and patient consent for joint injection.
16.	Inpatient Algorithm for Warfarin Maintenance Dose	The audit results indicate that hospitalised patients on Warfarin often fall below their target international normalized ratio (INR) therapeutic range. This outcome is primarily due to the absence of a dosing algorithm for Warfarin in the hospital. **Action:** Introduce the standardised dosing method, (Dawson algorithm).
Surgical Specialities		
17.	Cataract Primary Care Clinic	The majority of those seen in the Cataract Clinic are listed for surgery or given a suitable management plan. **Actions:** Nurse monitoring ahead of clinic, for alerts if a patient is diagnosed with a learning disability or dementia. Optometrist to request B scan for patient on the day of clinic. Doctor to perform B scan on the day and advise appropriate action.
18.	Orthoptic Compliance with Standard Operating Procedure (SOP) - Paediatric Was Not Brought	This audit has demonstrated overall good compliance with our SOP of 'Paediatric patients not brought to their Orthoptic only appointment.' **Actions:** Clinicians to complete ICE requests (Sunquest ICE is an electronic system for requesting Pathology tests and accessing Radiology and Pathology results) as soon as completing notes on MediSIGHT to ensure completed. If unable to complete, email Safeguarding Lead, to complete.
19.	Patient Communication Audit in Virtual Fracture Clinic (VFC)	This audit found there was a significant gap between the expected routine use of Fracture Risk Assessment Tool (FRAX) scores and the actual low utilisation rate. As well

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		as documentation shortfalls, meaning not all necessary data was collected consistently. **Actions:** create mandatory field for mobile number on path point. Referral department - to ensure the correct mobile number is provided. VFC leaflet/information to be given to patient ensuring mandatory tick box to be completed?
20.	Surveillance Cystoscopy; Are We Following the NICE Guidance	The audit found that full compliance was observed for low grade group. Partial compliance was observed for intermediate grade group. For high grade group, standards were almost met. However, the standard for upper tract imaging was not adhered to in the majority. **Actions:** Alerts to be sent on ICE for every high-grade Non-Muscle Invasive Bladder Cancer (NMIBC) when the annual upper tract imaging is due. To discuss with Information Technology Team, the relevant requirements and implement. ICE should block the request for low grade NMIBC cystoscopy at 12 months if previous was recurrence free. To discuss with IT and implement the relevant changes.
	Urgent & Emergency	
21.	Improving Transient Ischaemic Attack (TIA) Pathway for Emergency Medicine Department and GP Surgeries	The compliance level for the 2023 TIA guidelines fell below the expected requirement. The Stroke Team is currently examining these guidelines and aims to incorporate the revised version into the ongoing improvement cycle.
22.	An Audit Analysis of the Efficiency and Effectiveness of Same Day Emergency Care (SDEC) Acute Medicine Clinics	This audit highlighted several areas of non-compliance with the local Standard Operating Procedure (SOP). Moreover, evidence suggests that proper utilisation of the early discharge follow-up clinic can significantly alleviate the burden on General Practitioners (GPs) and reduce the need for specialty follow-up. **Actions:** Update to the Same Day Emergency Care Clinic SOP. Update the ICE referral process for clinic referrals.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Gather patient experience feedback for those attending the SDEC Clinic.
23.	Re-Audit of Venous Thromboembolism (VTE) Prophylaxis for Patients Admitted Under Acute Medicine	In this audit 87.5% had their VTE prophylaxis within 14 hours of admission (standard is 100%). **Actions:** Educate all doctors in the hand over/safety brief in Acute Medical Assessment Unit (AMU) / Emergency Department and / Same Day Emergency Care (SDEC). Prescribe Clexane dose for the next drug round. Ensure every patient has Thrombo–Embolus Deterrent (TEDS) prescribed whilst awaiting OGD (GI Bleed) or Computed Tomography scan (CT scan) (suspected bleed).
Women & Children		
24.	Analysis of Medication Errors on the Paediatric Ward Including Administration and Prescribing Errors	Across the data collected the most common Type of error was prescribing errors which is comparable with published data. When analysing the sub-Type of errors wrong frequency was highlighted via the DATIX system as the most common error. **Actions:** Paediatric prescribing will be added to induction for all new trainees .at WHH Information booklet to be shared regarding Paediatric prescribing to trainees at induction, to highlight the differences associated with Paediatric prescribing. Staff to be informed about the expected standards of reporting incidents on the Datix Risk Management System, incident module including medication incidents. To be shared as safety feature via nursing and doctor handovers.
25.	24-hour Discharge Summary Compliance in Gynaecology Patients in Other Wards and Departments	Although discharge summaries are being completed in a small number of areas they are being left in draft and not authorised/completed. **Actions:** Hysterosalpingogram (HSG) patients not to be included as inpatient admissions to Gynaecology. Discussion to be had with Clinical Coding and Interventional Radiology staff. [the process for the Gynaecology Assessment Unit (GAU) discharges is currently via Same Day Emergency Care

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		(SDEC) on Lorenzo. During the audit GAU paperwork had been on paper but is now digitally processed. Dissemination of audit results via Audit Meeting to remind clinicians that discharge summaries need to be completed for cancelled/postponed surgeries.
26.	Re-audit: Uterine Artery Dopplers for Women Who Are at High Risk of Fetal Growth Restriction (FGR)	The audit findings suggests that the quality improvement work has been successful in ensuring that women who are assessed as high risk for FGR are having a referral for a uterine artery doppler scan, which is subsequently completed within the correct time frame. **Action:** Ongoing data collection monthly as required by Local Maternity and Neonatal System (LMNS) for quarterly assurance meetings. This audit has been awarded the 'Clinical Audit Award of Excellence'.
27.	Neonatal Therapeutic Cooling Babies Audit 2024	This is a retrospective annual audit of babies receiving cooling. In this audit cycle all babies transferred and cooled. 5 of the 7 had documented notes of achieving recommended target temperature within 6 hrs. The 2 remaining 1 had not been documented and other did not have enough time to complete as the transport arrived within 45 minutes of commencing cooling. **Action:** Single point lesson shared - preterm cooling to go through Connect Northwest.

*The Clinical Audit Award of Excellence is the Trust based scheme that awards those clinical audits that meet defined criteria. This includes adhering to the Clinical Policy in conducting the clinical audit and in promoting learning outcomes.

2.7 Information on Participation in Clinical Research Development 2023-24.

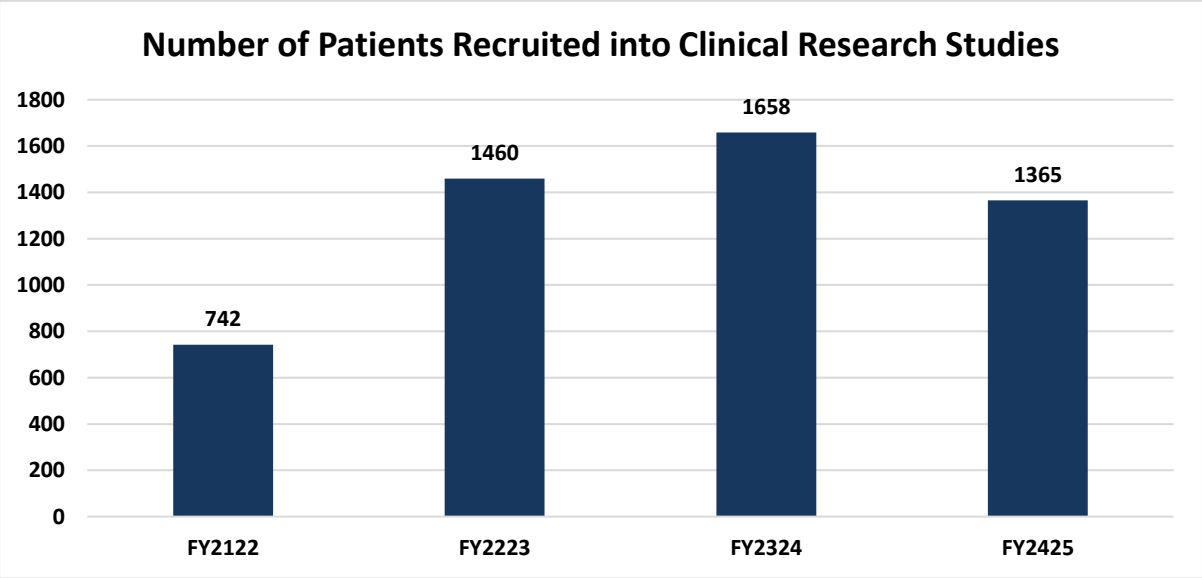
Introduction

Clinical Research is vital to improve the knowledge needed to develop the current and future quality of care for patients. Carrying out high quality research gives the NHS the opportunity to minimise inadequacies in healthcare and improve the treatments patients receive. The Trust is only involved with research studies that have received a favourable opinion from the Research Ethics Committee within the National Research Ethics Service (NRES), signifying the research projects are of high scientific quality and have been risk assessed.

The Research, Development and Innovation Department (RD&I) forms part of the Quality Academy and is committed to providing patients with the opportunity to participate in research if they wish. The aim is to ask all eligible patients if they would like to participate in a clinical trial.

Overview of Research Activity

The number of patients participating in research approved by a research ethics committee was 1365 as detailed below. This includes those involved in National Institute for Health and Care Research (NIHR) and non NIHR Support research studies. The 2024-25, NIHR Portfolio Study data was not signed off nationally at the time of reporting. Therefore, the patient participation figure is, therefore, un-validated at this time.



Data Source: NIHR Open Data Platform (odp.nihr.ac.uk) accessed 02/04/2025. Non-Portfolio data extracted from Local Portfolio Management System 03/04/2025.

The NIHR portfolio studies are high quality research that have full funding and have undergone a rigorous peer review to be adopted onto the portfolio.

Participation in clinical research demonstrates he commitment of Warrington and Halton Teaching Hospitals, NHS Foundation Trust to improving the quality of care offered, contributing to wider health improvement. The opening of the Halton Clinical Research Unit in 2021 has been fundamental in creating an accessible platform for the public to access research trials.

Warrington and Halton Teaching Hospitals NHS Foundation Trust was involved in recruiting to 29 clinical research studies during 2024-25, covering 14 NIHR Portfolio specialties and 2 non-Portfolio studies as outlined in the Table below.

Study Type	Study Sponsor	NIHR Portfolio Speciality	Short Name	Study Title	Recruitment
Commercial	MODERNA, INC.	Infection	Nova301 - mRNA-1403-P301	A Phase 3, Randomized, Observer-blinded, Placebo-Controlled Study to Evaluate the Safety and Efficacy of mRNA-1403, a Multivalent Candidate Vaccine to Prevent Norovirus Acute Gastroenteritis in Adults ≥18 Years of Age	113
Commercial	SANOFI	Children	HARMONIE sub-study	HARMONIE sub-study	5
Non-Commercial	BELFAST HEALTH AND SOCIAL CARE TRUST	Critical Care	MARCH	Mucoactives in Acute Respiratory failure: Carbocisteine and Hypertonic saline	1
Non-Commercial	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Gastroenterology and Hepatology	IBD Bioresource	The UK Inflammatory Bowel Disease Bioresource: Progressing from Genetics to Function and Clinical Translation in Crohn's Disease & Ulcerative Colitis	7
Non-Commercial	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Gastroenterology and Hepatology	PBC Genetics Study	Investigation of the Genetic and Molecular Pathogenesis of Primary Biliary Cirrhosis	1
Non-Commercial	Imperial College of Science, Technology and Medicine	Diabetes, Metabolic and Endocrine	DRN 552 (Incident and high-risk Type 1 diabetes cohort – ADDRESS-2)	An incident and high-risk Type 1 diabetes research cohort - After Diagnosis Diabetes Research Support System-2 (ADDRESS-2)	4

Non-Commercial	INTENSIVE CARE NATIONAL AUDIT AND RESEARCH CENTRE (ICNARC)	Critical Care	UK-ROX	Evaluating the clinical and cost-effectiveness of a conservative approach to oxygen therapy for invasively ventilated adults in Intensive Care.	42
Non-Commercial	LOTHIAN	Critical Care	GenOMICC	Genetics of susceptibility and mortality in Critical Care (GenOMICC)	11
Non-Commercial	LOTHIAN	Critical Care	The ABC post-Intensive Care trial	Anaemia management with red Blood Cell transfusion to improve post-intensive care disability: a randomised controlled trial	2
Non-Commercial	University College London	Anaesthesia, Perioperative Medicine and Pain Management	Perioperative Quality Improvement Programme: Patient Study	Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme	13
Non-Commercial	University College London	Children	Neonatal nursing retention	Job satisfaction and intent to stay in Neonatal nursing: an exploration of staff in England and Wales	3
Non-Commercial	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	Gastroenterology and Hepatology	NAFLD BioResource	The NAFLD BioResource, part of the NIHR BioResource – A Research Study to Characterise Novel Clinical and Genetic PhenoTypes, and Understand the Natural History of Non-Alcoholic Fatty Liver Disease (NAFLD)	2
Non-Commercial	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	Critical Care	MOSAICC	Evaluating the clinical and cost-effectiveness of Sodium Bicarbonate administration for critically ill patients with Acute Kidney Injury and metabolic acidosis	3

Non-Commercial	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	Musculoskeletal and Orthopaedics	RaCeR 2	Clinical and cost-effectiveness of individualised (early) patient-directed rehabilitation versus standard rehabilitation after surgical repair of the rotator cuff of the shoulder: a multi-centre, randomised controlled trial with integrated Quintet Recruitment Intervention	10
Non-Commercial	University of Aberdeen	Children	SPIROMAC	Spirometry to Manage Asthma in Children (SPIROMAC)	2
Non-Commercial	University of Birmingham	Ageing	FORCE: SEE Study	Frailty and Outcomes Record in Clinical Environments: probable Sarcopenia, geriatric Evaluation, and Events	18
Non-Commercial	University of Birmingham	Cancer	MITHRIDATE Trial Version 2.0 10-June-2019	MITHRIDATE: A phase III, randomised, open-label, Multicenter International Trial comparing ruxolitinib with either HydRoxycarbamIDe or interferon Alpha as first line Therapy for high-risk polycythemia vera	1
Non-Commercial	University of Edinburgh	Surgery	MOTION Trial Protocol V1.0	What is the clinical-effectiveness and cost-effectiveness of surgery with medial opening wedge high tibial osteotomy (HTO) compared with non-surgical treatment in the management of osteoarthritis (OA) of the knee in patients younger than 60 years? (MOTION Trial)	0
Non-Commercial	University of Leicester	Ageing	CHARMER WP4 Definitive Trial	Comprehensive Geriatrician led Medication Review (CHARMER) - Work Package 4 Definitive Trial	1005
Non-Commercial	University of Manchester	Critical Care	Intensive care decision-making, survival and dying well	Intensive care decision-making, survival and dying well: How do the experiences of Intensive Care patients and their end-of-life wishes would affect their willingness to accept intensive care treatment at different chances of survival?	1

Non-Commercial	University of Manchester	Musculoskeletal and Orthopaedics	Toxicity from biologic therapy (BSRBR)	Prospective observational study of the long-term hazards of biologic therapy in rheumatoid arthritis	3
Non-Commercial	University of Manchester	Reproductive Health and Childbirth	The Tommy's Project	The Tommy's Project - a coordinated antenatal and tissue data study of pregnancy outcome and related disease	39
Non-Commercial	University of Nottingham	Stroke	Pharyngeal Electrical stimulation (PES) for Post Stroke dysphagia (PSD	Pharyngeal Electrical stimulation for Acute Stroke dysphagia Trial (PhEAST)	1
Non-Commercial	University of Oxford	Critical Care	Threshold for Platelets Study (T4P)	The Threshold for Platelets (T4P) study: a prospective randomised trial to define the platelet count below which critically ill patients should receive a platelet transfusion prior to an invasive procedure	2
Non-Commercial	University of Oxford	General Practice	DURATION UTI	Impact of duration of antibiotic therapy on effectiveness, safety and selection of antibiotic resistance in adult women with urinary tract infections (UTI): a randomised controlled trial	4
Non-Commercial	University of Oxford	Trauma and Emergency Care	CRAFFT – Children's Radius Acute Fracture Fixation Trial	CRAFFT – Children's Radius - Acute Fracture Fixation Trial: A multi-centre prospective randomised non-inferiority trial of surgical reduction versus non-surgical casting for displaced distal radius fractures in children.	2
Non-Commercial	University of Ulster	Critical Care	iRehab	Remote rehabilitation after ICU (iRehab)	2

Non-Portfolio	Royal Devon University Hospital	n/a	HELLO TRIAL	Protocol for a cluster randomised control trial evaluating the effectiveness of a "Hello" bundle intervention in reducing burnout among Intensive Care healthcare professionals	40
Non-Portfolio	Manchester University NHS Foundation Trust	n/a	KPI-NW	Evaluation of a Neonatal Early-Onset Sepsis Risk Calculator in the Northwest population	28
				TOTAL	**1365**

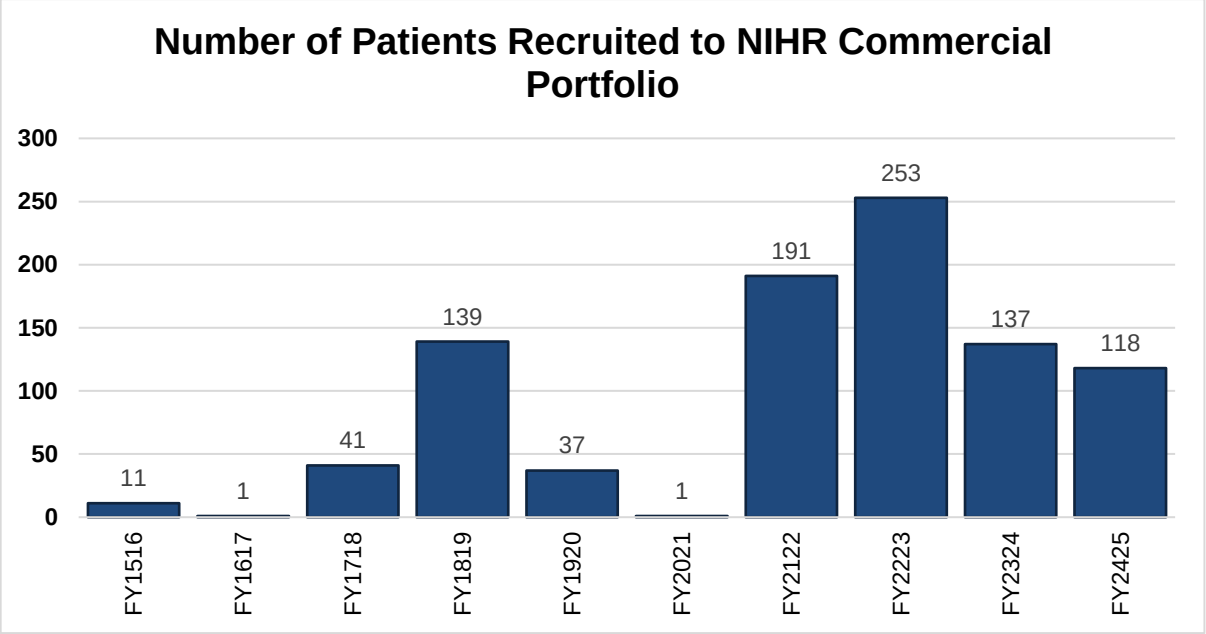
Data Source: NIHR Open Data Platform (odp.nihr.ac.uk) accessed 02/04/2025. Non-Portfolio data extracted from Local Portfolio Management System 03/04/2025.

	Commercial		
	FY2324	**FY2425**	**% Improvement**
Number of Studies Opened	2	2	0.0%
Number of Participants Recruited	137	118	-13.9%

	Non-Commercial		
	FY2324	**FY2425**	**% Improvement**
Number of Studies Opened	12	7	-41.7%
Number of Participants Recruited	1521	1187	-22.0%

	Non-Portfolio		
	FY2324	**FY2425**	**% Improvement**
Number of Studies Opened	1	1	0.0%
Number of Participants Recruited	2	68	3300.0%

Data Source: NIHR Open Data Platform (odp.nihr.ac.uk) accessed 02/04/2025. Non-Portfolio data extracted from Local Portfolio Management System 03/04/2025.



Data Source: NIHR Open Data Platform (odp.nihr.ac.uk) accessed 02/04/2025.

The RD&I department continue to work in collaboration with Halton Clinical Research Unit (HCRU) partners, National Institute for Health and Care Research (NIHR), Regional Research Delivery Network Northwest (RDNNW) and Liverpool University Hospitals NHS Foundation Trust (LUHFT). Recruitment to commercial studies on the HCRU has increased from 96 in FY2023-24 to 118 in FY2024-25.

The Partnership is overseen by the Research Partnership Board, consisting of senior representatives from each of the HCRU partners. The Partnership Board has been an Essential Oversight and Action Group, supporting Warrington and Halton Teaching Hospitals, Foundation Trust in establishing itself as a preferred site for phase II+ commercial research studies with a good reputation for delivery to time and target.

Improving the offer of research opportunities to patients

Scoping for new studies

RD&I scope out new studies for WHH through an "expressions of interest" portal and proactive approaches to Research Teams and commercial sponsors. The RDN launched a new expressions of interest (EoI) portal for commercial trials in February 2025. Data is not yet available for this portal. Figures provided are for commercial trials offered in FY24-25 up to 31st January 2025 and non-commercial trials are for the full financial year.

323 studies were assessed for suitability with 25 resulting in an expression of interest being submitted in FY2024-25.

Status	Study Type	No. Studies
Expression of Interest Submitted	Commercial	14
	Non-commercial	11
	Non-portfolio	1
	EoI Total	**26**

WHH did not express interest in 291 of the studies offered, with the following table categorising the reasons why these studies were not deemed suitable.

NIHR Commercial Portfolio		
TOTAL	220	
Decline Reason	No. Studies	%
No spec service	105	47.7%
No interest	38	17.3%
No suitable PI	15	6.8%
Study Design - Phase 1	13	5.9%
Study design - General	11	5.0%
Not suitable for site	10	4.5%
PI capacity	10	4.5%
No pt population	7	3.2%
Lack of patient population	4	1.8%
Decline reason not recorded	3	1.4%
Clinical capacity - Research Nurses	3	1.4%
Deadline passed	1	0.5%
Study timelines	1	0.5%

NIHR Non-Commercial Portfolio		
TOTAL	71	
Decline Reason	No. Studies	%
No spec service	23	32.4%
No interest	18	25.4%
Study design	10	14.1%
PI capacity	7	9.9%
Decline reason not recorded	5	7.0%
No suitable PI	2	2.8%
Already recruiting	1	1.4%
Clinical capacity - departmental	1	1.4%
Lack of patient population	1	1.4%
Not suitable for site	1	1.4%
Phase 1	1	1.4%
RN Capacity	1	1.4%

Developing Principal Investigator Capacity

The capacity of the Trust to conduct research is heavily influenced by the number of Principal Investigators (PIs) employed. To have a sustainable research workforce, the PI pool needs to be both rich and diverse. To improve the overall capacity of the Trust for research, various schemes are in process, including:

- Review of Programme Activity allocations to identify areas where there is potential for PI growth.
- Establishment of a PI forum to provide peer support or research leaders and aspiring research leaders.
- A scheme for Nurses Midwives and Allied Health Professionals (NMAHPS) led by a research active advanced physiotherapist, to develop a Programme of capacity and capability building initiatives.
- Embed research training in the Preceptorship Training Programme to ensure new starters are aware of the value of research and have the information required to identify research opportunities and further learning.

Improving Access to Clinical Trial Opportunities - Pathway to Research

In 2023, the Pathway to Research registry was launched to connect patients directly with research opportunities. This initiative allows patients to access new studies in a timely manner while providing the Trust with an additional avenue for participant recruitment.

To date, 289 individuals have consented to join the registry, including 49 in FY24/25. The registry has already proven its value as an efficient tool for recruitment, playing a key role in enrolling participants for a recent Norovirus vaccine trial

Learning from Experience

Optimising Research Management: Lessons Learned from Early Studies at the HCRU
The research activities conducted at the Halton Clinical Research Unit (HCRU) have been established and delivered in collaboration with the Research Delivery Network (formerly Clinical Research Network) and Liverpool University NHS Foundation Trust. All commercial research activities are appropriately costed, with the expectation that costs will be recovered in a timely manner once each study is completed.

Experience from one of the earlier studies at HCRU highlighted the importance of detailed tracking of research activities and personnel to ensure optimal income recovery from projects. Lengthy discussions and negotiations with research partners resulted in delays in recouping the expected income. However, this issue has since been resolved, and key lessons have been learned. More robust systems for tracking and monitoring activities have now been implemented to prevent similar delays in future studies and ensure income maximisation.

Participant Research Experience Survey (PRES)
The Participant Research Experience Survey (PRES), conducted by the National Institute for Health Research (NIHR) Research Delivery Network (RDN), gathers valuable feedback to enhance the experience of research participants. The RD&I Team has reviewed local PRES feedback from the Warrington and Halton sites, revealing overwhelmingly positive responses, as illustrated by the word cloud below. However, a few areas for improvement have been identified.

Key areas for enhancement include improving the accessibility of research locations, ensuring participants are kept updated on research results, and addressing participant reimbursement. The team is actively exploring ways to address these challenges and implement meaningful improvements.

In addition, efforts are underway to increase the PRES response rate to gain a more comprehensive understanding of participants' experiences. As part of a Quality Improvement Project, the team has conducted a process mapping exercise and identified key actions to boost response rates, ensuring a broader and more representative perspective on research engagement.

Continuous Quality Improvement (CQI)
The majority of the R&D Team have now completed the Quality Improvement Foundation course. This has encouraged members of the team to take up the Practitioners course as well as giving confidence to the team to pursue their own projects. Projects undertaken include:

- Improving PRES response rate
- Reducing out of window sickness visits
- Replacing physically mailed out GP letters with electronic letters issued from Lorenzo.

Impact

Impact of the NIHR Associate Principal Investigator Scheme

The National Institute for Health and Care Research Associate Principal Investigator (NIHR API) scheme is a six month in-work training opportunity, providing practical experience for health and care professionals starting their research career.

People who would not normally have the opportunity to take part in clinical research in their day-to-day role have the chance to experience what it means to work on and deliver an NIHR portfolio trial under the mentorship of an enthusiastic Local Principal Investigator (PI).

The scheme offers numerous benefits to NHS Trusts by building research leadership skills, increasing the capacity to conduct research studies and boosts the Trust's appeal to funding bodies and commercial research partners.

Through ongoing promotion and the identification of suitable projects, WHH has successfully guided 4 individuals through the Associate Principal Investigator (API) scheme during FY24-25, specifically within the NIHR specialities of General Practice, Infection and Critical Care. Leveraging this experience, there are plans in place to expand the API scheme across the Trust to identify additional candidates from various specialties.

Commercial Research Delivery Centre

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) will play a vital role as part of the newly established NIHR Commercial Research Delivery Centre (CRDC) hosted by the NHS University Hospitals of Liverpool Group (UHLG). The CRDC, funded through a £100

million government-private initiative, will accelerate commercial studies across Cheshire and Merseyside, enabling rapid access to innovative treatments through clinical trials. WHH, alongside other key organisations in the region, will contribute to the delivery of cutting-edge research in areas such as cancer, respiratory illness, obesity, and infectious diseases. By fostering collaboration with primary and social care, voluntary organisations, and secondary care partners, WHH will help make Cheshire and Merseyside a hub for pioneering commercial research, giving patients unprecedented opportunities to access new treatments and preventative healthcare solutions. This initiative demonstrates WHH's commitment to and impact of improving health outcomes and advancing the region's research capacity.

Recruitment Performance

The positive impact of WHH's committed workforce and sustained research efforts is clearly demonstrated by the notable growth in recruitment to research studies. In year FY2024-25, a total of 1637 participants were successfully recruited across 22 studies within the NIHR portfolio. The national data set for recruitment is yet to be confirmed, however preliminary data shows recruitment for FY2024-25 to all NIHR portfolio studies to be 1305, achieved over 27 studies across 14 specialities. 91.4% of recruitment has come from 5 studies.

Study Type	Short Name	Speciality	Recruitment	% Total Recruitment
Non-Commercial	CHARMER WP4 Definitive Trial	Ageing	1005	77.0%
Commercial	Nova301 - mRNA-1403-P301	Infection	113	8.7%
Non-Commercial	The Tommy's Project	Reproductive Health and Childbirth	39	3.0%
Non-Commercial	FORCE:SEE Study	Ageing	18	1.4%
Non-Commercial	Perioperative Quality Improvement Programme: Patient Study	Anaesthesia, Perioperative Medicine and Pain Management	17	1.3%

Data Source: NIHR Open Data Platform (odp.nihr.ac.uk) accessed 02/04/2025.

In addition to NIHR portfolio studies, WHH R&D recruited 68 participants to two non-portfolio studies.

This upward trajectory in recruitment over the past two years has yielded tangible benefits for the community served by WHH. The increased access to high-quality research signifies a meaningful contribution to advancing medical knowledge and potentially enhancing healthcare outcomes within the community. The organisations dedication to research endeavours is thus resulting in positive outcomes and increased opportunities for community members to participate in and benefit from valuable research initiatives.

Preceptorship Training Programme

The Research and Development Preceptorship Training Programme, accredited by the RCN in 2024, has been delivered to newly qualitied NMAHPs on a monthly basis over the last 12

months. The Research element of the training has received overwhelmingly positive feedback from participants and led to an improved awareness and appreciation for research.

Reputation and recognition

Elevating WHH's research reputation attracts new studies and staff while also increasing awareness among patients and the public about opportunities for involvement. A key highlight of WHH RD&I's commitment to excellence in 2024/25 was a presentation at the National Research and Development Forum Annual Conference. Titled 'Unleashing the Potential of NMAHPs in Research,' the presentation showcased WHH's capacity-building efforts and sparked meaningful, long-lasting discussions in this important area.

Strategic Alignment

RD&I pursue strategic alignments and collaborations with academic institutions and across the wider system with other NHS organisations in the primary and secondary and tertiary care setting to further increase the offer of research to patients. Key examples as follows:

Halton Clinical Research Alliance

The HCRA is a joint project between WHH R&D, Castlefield's Health Centre and Grove Medical Practice Teams to increase research activity across Halton. The focus for the year was to form a support network for research active practices and explore working modalities for research delivery in primary care across Halton. The funding from the RDN helped to establish the groundwork required to support practices through their research journey.

The HCRA project continued unfunded through FY24-25. The HCRA still made progress and successfully facilitated the creation of a Primary Care Network (PCN) Research Lead post for Runcorn PCN. This marks a significant commitment to research from the PCN and enhances the PCN's capacity for research and collaboration.

As the project continues, the HCRA will be seeking further funding opportunities to capitalise on the success to date.

Primary Care

Warrington and Halton places have great potential for research capacity and capability. Cross-setting collaborations can help primary care integrate research into business as usual, increasing the research opportunities available to the region. Collaborations such as the HCRA aim to identify potential projects that can be seamlessly delivered across the Primary Care/Secondary Care interface or within alternative community settings.

Higher Education Collaborations

WHH continue to scope out opportunities to partner with Higher Education Institutions (HEIs), including Edge Hill, John Moore's and Chester Universities, and through the Applied Research Collaboration Northwest Coast, to develop the academic research portfolio. Collaborations of this nature will enhance opportunities for WHH staff and patients to co-produce research proposals which meet the needs of the local population and secure the necessary funding to undertake that research. This will enable Warrington and Halton Teaching Hospitals, NHS Trust to apply to competitive funding streams in partnership with other Health and Social Care

organisations to secure research funding which has the potential to attract further research capacity funding in later years also supporting recruitment and retention.

Two examples within this year include working with University of Chester on an Evaluation of Health Hubs and a collaborative funding bid for £150k with University of Liverpool Department of Continuing Education and NHS Research and Development Northwest.

Bridgewater Community Healthcare NHS Foundation Trust Integration and Collaboration

Ongoing discussions with the Research and Development Department at Bridgewater Community Healthcare NHS Foundation Trust aim to identify opportunities for collaboration and integration. The goal is to enhance research opportunities for the Warrington and Halton communities and expand the commercial research portfolio into community healthcare settings. An example of collaborative working and integration includes building on existing strengths to develop a collaborative funding bid for £150k to the research Delivery Network strategic Fund for research in the community settings.

Research Oversight Sub Committee

The RD&I Department has prioritised strengthening the governance and oversight of WHH's research activities to ensure strategic alignment with the Trust's objectives and integration with Bridgewater Community Healthcare (BCH). This has included the ongoing internal review and streamlining of governance processes to accelerate trial setup, improve operational efficiency, and maintain compliance with governance standards. By aligning efforts across both organisations, the initiative aims to expand research capacity, ensure financial sustainability, and enhance the appeal of WHH and BCH as a partner for industry sponsors. A Research Oversight Committee has been established to oversee these efforts and provide assurance to the Board of Directors. The first meeting to launch this collaborative approach took place on 15th January, marking an important step forward in advancing these priorities.

2.8 Information on the use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework 2023-24

The Commissioning for Quality and Innovation (CQUIN) payment framework aims to support the cultural shift towards making quality the organising principle of NHS Services. In particular, it aims to ensure that local quality improvement priorities are discussed and agreed at Board of Directors level within and between organisations. The CQUIN payment framework is intended to embed quality at the heart of commissioner-provider discussions by making a small proportion of provider payment conditional on locally agreed goals around quality improvement and innovation.

A proportion of Warrington and Halton Teaching Hospitals NHS Foundation Trust's Foundation Trust's income is normally conditional on achieving quality improvement and innovation goals agreed as part of the contract.

During 2024/25 the Commissioning for Quality and Innovation was paused. A set of non-mandatory quality indicators were published by NHS Futures, which Trusts could use as an approach to quality improvement activity during the CQUIN pause. Warrington and Halton Hospitals chose to locally agree to continue with the existing CQUINs to continue to promote continuous quality improvement.

CQUIN ID	CQUIN Title	Target	Compliance Quarter 1	Compliance Quarter 2	Compliance Quarter 3	Compliance Quarter 4- Prelim
01	Flu Vaccinations for frontline healthcare workers (annual CQUIN)	Min – 75% Max – 80%	N/A	N/A	42.10%	42.7%
02	Supporting patients to drink, eat and mobilise after surgery (documentation) (22/23 CQUIN)	Min – 70% Max - 80%	62.6%	49%	No Data received	No Data received
03	Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	Min – 60% Max - 40% (NB lower % = more compliant)	14%	42%	86%	No Data received
04	Compliance with timed diagnostic pathways for Cancer Services	Min - 35% Max - 55%	49%	51%	59.40%	55.7% (data up to February 2025)
05	Identification and response to frailty in emergency departments (New)	Min – 10% Max – 30%	9%	13%	15%	13.12%
06	Recording of and appropriate response to NEWS2 score for unplanned critical care admissions	Min – 10% Max - 30%	The CQUIN 06 work has been paused for 6 months. As an interim monitoring process an additional question will be added to the current NEWs audit to screen medical input post escalation.			

CQUIN ID	CQUIN Title	Target	Compliance Quarter 1	Compliance Quarter 2	Compliance Quarter 3	Compliance Quarter 4- Prelim
			If the NEWS audit identifies high escalations or concerns within any speciality, this will be escalated to the Department Clinical & Governance Leads for review to determine any change in clinical practice/ action required. The Associate Medical Director of Patient Safety has offered her support with this. A Standard Operating Procedure (SOP) is currently being developed, with the aim to clarify the escalation process for deteriorating patients within the Emergency Department (ED). This will be developed in conjunction with other specialities (Medicine, Surgery, Orthopaedics etc) to have a clear pathway of escalation including deterioration whilst awaiting review by the appropriate speciality. The Clinical Director of the Urgent and Emergency Care will lead on this / assign accordingly within the team.			
07	Assessment and documentation of pressure ulcer risk	Min – 70% Max – 85%	49%	52%	51%	50.36%

The following information provides details on the plans for improvements for those CQUINs that have not been achieved in 2025-26.

Plan for Improvement Updates: Non-Financial Incentive CQUIN		
ID	**CQUIN Title**	**Improvement Work Updates**
CQUIN 01	Flu Vaccinations for frontline healthcare workers	**Opportunity for Improvement**: Reduced appetite amongst healthcare staff to be vaccinated within the Trust. This has also been recognised Nationally **Action Point / Task Required**: Communication increased to educate staff, providing a level of understanding. Further offer to access to the Occupational Health Specialist Team for further education and reassurance. The communication plan will be refreshed by the OH Specialist Nurse and link with

Plan for Improvement Updates: Non-Financial Incentive CQUIN

<table>
<tr><th>ID</th><th>CQUIN Title</th><th>Improvement Work Updates</th></tr>
<tr><td></td><td></td><td>
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<tr><td></td><td>external advice and internal trends.</td></tr>
<tr><td></td><td>The Vaccination Team will be visible across both Trust sites and all shifts. With access to the vaccination at the front of the Trust at Warrington and the canteen at Halton for a limited time.</td></tr>
<tr><td>Increased patient facing staff identified in the Trust due to using Employment Service Register (ESR) and codes staff roles are identified to on ESR.

This change increased the numbers of patient facing staff although this may not be considered a patient facing role locally. Unfortunately, the measurement system Nationally does not consider local measures and thus impacts on the uptake percentage.</td><td>The data from ESR will need to be frequently updated during the campaign. This will provide the Specialist team patient facing areas to target.

Patient facing staff not receiving the vaccination will be personally invited to have the vaccination. This data will be provided by ESR.</td></tr>
</table>
</td></tr>
<tr><td>CQUIN 03</td><td>Prompt Switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet swich criteria.</td><td>
<table>
<tr><th>Opportunity for Improvement</th><th>Action Point / Task Required</th></tr>
<tr><td>Training / Education Sessions</td><td>Dedicated teaching to Foundation Year 1 and 2 doctors in the teaching Programme.

Sessions arranged for June and August 2025.</td></tr>
<tr><td>Dedicated IVOS QIP / audit</td><td>Antimicrobial Pharmacy Team is now fully staffed.</td></tr>
<tr><td>IVOS Form Compliance Dashboard</td><td>Discussions taking place to explore the development of an IVOS Form Compliance dashboard to monitor the use of the IVOS Tool</td></tr>
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Plan for Improvement Updates: Non-Financial Incentive CQUIN		
ID	**CQUIN Title**	**Improvement Work Updates**
CQUIN 07	Assessment and documentation of pressure ulcer risk.	

Opportunity for Improvement	**Action Point / Task Required**
Ward walkarounds	Deputy Chief Nurse/Director of Governance and Associate Chiefs of Nursing to undertake ward walk arounds to assess each ward area.
Education	CPD funding has been sourced to support in the education around this.
Pressure Ulcer Workplan	Trust wide pressure ulcer prevention workplan is currently being reviewed and updated.

2.9 Registration with the Care Quality Commission (CQC) and Periodic/Special Reviews.

Warrington and Halton Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Teaching Hospitals NHS Foundation Trust during 2024-25.

The Trust is registered to provide the following services:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and Midwifery Services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder, or injury

Warrington and Halton Teaching Hospitals NHS Foundation Trust has not been subject to any special reviews or investigations by the Care Quality Commission during 2024/25.

New Service Registered.

There were no additional services requiring registration during 2024/25. All notifications relating to changes at Director level were submitted.

CQC Engagement.

The Trust was inspected in 2019 where it was rated as 'good'. There was one further announced inspection by the CQC in September 2023. The service was inspected as part of the National Maternity Inspection Programme which involved an announced inspection of Maternity Services at each Trust. The CQC continued to rate our Maternity Services as 'Good'. No service within Warrington and Halton Teaching Hospitals, NHS Foundation Trust has been inspected during 2024-2025.

The CQC have continued their regulatory approach focusing upon CQC Engagement Meetings which have been held on a quarterly basis with the Trust throughout the reporting period 2024-25. The CQC launched a new regulatory model in 2024 using a Single Assessment Framework.

Post CQC Inspection Activity.

The post inspection action plan from the Trust's 2019 CQC inspection was completed in November 2020. Improvements and sustainability are supported and monitored through the Quality Compliance Oversight Group (QCOG) held bi-monthly by the Chief Nurse. All CQC matters, compliance and external inspections are monitored through QCOG. Matters are reported into the Quality Assurance Committee, which in turn provides assurance to the Trust Board of Directors.

2.10 Information on the Quality of Data.

High quality data, captured at the point of care, underpins the Trust's ability to deliver care that is both safe and efficient enabling learning and improvement to be focused and meaningful. This forms the basis of robust systems of business intelligence that are integral to our day-to-day work.

Improving data quality requires effort, resources, and commitment at all levels in the Trust and requires a focus on user behaviour and improving how staff interact with the Trust's Electronic Patient Record and core systems.

The Trust will be taking the following actions to improve data quality: the Trust is monitored internally, locally, and nationally on the clinical data it generates and publishes.

The obligations upon all Trust staff to maintain accurate records are:

- Legal (Data Protection Act 2018)
- Contractual (Contracts of employment)
- Ethical (Professional codes of practice)
- Regulatory (Care Quality Commission, Good Governance)

2.11 NHS Number and General Medical Practice Code Validity

Warrington and Halton Teaching Hospitals NHS Foundation Trust submitted anonymised clinical data records for patients seen and treated during April – March 2024-25* and 2023-24** to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics

which are included in the latest published available data at the time of writing this report. The Trust evidences a positive position when compared with the national average. This is provisional information released for NHS managerial/Operational purposes only, based on Data published on 16/5/2025. The final published data position report for month 12 is due to be published on 10/06/2025 for the percentage of records and GP Practice Codes.

The percentage of records in the published data which included the Patient's valid NHS Number was as follows:					
National Data Set	**Trust Valid**	**National Average Valid**	**Date Range**	**A&E Type**	**Financial Year**
Admitted Patient Care	99.90%	99.7%	Apr 2024 - Mar 2025		2024/25
Outpatient Care	99.90%	99.7%	Apr 2024 - Mar 2025		
Accident and Emergency (A&E) Care	99.50%	98.20%	Apr 2024 - Mar 2025	Type 1	
Accident and Emergency (A&E) Care	100.00%	92.20%	Apr 2024 - Mar 2025	Type 3	
Admitted Patient Care	99.90%	99.70%	Apr 2023 - Mar 2024		2023/24
Outpatient Care	99.90%	99.70%	Apr 2023 - Mar 2024		
Accident and Emergency (A&E) Care	99.60%	98.90%	Apr 2023 - Mar 2024	Type 1	
Accident and Emergency (A&E) Care	99.50%	92.60%	Apr 2023 - Mar 2024	Type 3	
Data source provided from SUS – Cumulative year to date end of 2023/24					

GP Practice Codes **The percentage of records in the published data which included the patient's valid General Medical Practice Code was:**					
National Data Set	**Trust Valid**	**National Average Valid**	**Date Range**	**A&E Type**	**Financial Year**
Admitted Patient Care	100.00%	99.40%	Apr 2024 - Mar 2025		2024/25
Outpatient Care	100.00%	99.30%	Apr 2024 - Mar 2025		
Accident and Emergency (A&E) Care	100.00%	99.70%	Apr 2024 - Mar 2025	Type 1	
Accident and Emergency (A&E) Care	100.00%	97.90%	Apr 2024 - Mar 2025	Type 3	

Admitted Patient Care	100.00%	99.70%	Apr 2023 -Mar 2024		2023/24
Outpatient Care	100.00%	99.50%	Apr 2023 -Mar 2024		
Accident and Emergency (A&E) Care	100.00%	99.60%	Apr 2022 -Mar 2023	Type 1	
Accident and Emergency (A&E) Care	100.00%	97.50%	Apr 2022 -Mar 2023	Type 3	
Data source provided from SUS – Cumulative year to date end of 2024/25					

Warrington and Halton Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality and validity where it does not achieve 100% completeness.

- The Trust's Data Quality Team will continue to work closely with Operational Teams to ensure accuracy and completeness of the Trust key systems.
- A data quality dashboard has further supported the monitoring of data capture completeness.
- The Data Standards and Assurance Group continues to focus on areas requiring improvement relating to general data quality, Trust key performance indicators, operational areas and finance and contract performance.
- As part of the Trust governance structure the Data Standards and Assurance Group reports into the Information Governance and Corporate Records Sub-Group which in turn provides assurance to the Quality Assurance Committee.
- A Data Quality Policy is in place which identifies clear roles- and responsibilities for data quality and is routinely reviewed to ensure that it supports reporting and statutory obligations around national datasets.

2.12 Information Governance Assessment Report 2024-25.

The Trust uses the NHS England Data Security and Protection Toolkit (DSPT) in conjunction with the Datix Risk Management system, the Trust's ISMS (Information Security Management System), and the IT Health Cyber Assurance and Compliance System to ensure that it has robust data security and protection standards in place. The use of these systems informs the work of its Information Governance and Records Sub-Committee which was established to provide assurance that effective data security best practice mechanisms are deployed at the Trust.

The Information Governance and Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the Trust Board of Directors. The Trust's Senior Information Risk Owner (SIRO) chairs the Information Governance and Records Sub-Committee which is also attended by the Trust's Caldicott Guardian (Medical Director). The SIRO (Chief Information Officer) acts as the Trust's lead for information risk.

The Trust's most recent Data Security and Protection Toolkit assessment was finalised by Mersey Internal Audit Agency (MIAA) in June 2024 as part of the Trust's annual audit Programme. The Trust was the subject of a two-part Data Security and Protection Toolkit review conducted by MIAA from February to June 2024. Part one of the review findings, which focused on the veracity of the Trust's self-assessment of its data security and protection position,

concluded that the Trust's self-assessment deviated only minimally from the independent assessment. On that basis the assurance level awarded in relation to the veracity of the self-assessment was substantial assurance.

Part two of the 2024 review, which focused on the provision of an assurance level across the requirements within all 10 of the National Data Guardian security standards, concluded that the Trust merited a substantial assurance rating across 8 of the standards with two deserved of a moderate assurance rating. Therefore, the overall assurance level across all 10 National Data Guardian standards was rated as moderate.

In September 2024, the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF). The final submission deadline for 2024-25 DSPT CAF aligned assessment is scheduled for 30 June 2025 and updates can be accessed via the NHS Digital website: Organisation Search (dsptoolkit.nhs.uk)

The current Data Security and Protection Toolkit status for Warrington and Halton Teaching Hospitals NHS Foundation Trust following submission of the December 2024 baseline to NHS England is Approaching Standards. Plans for improvement are in place.

2.13 Payment by Results (PBR) Clinical Coding Audit.

The Trust remains committed to enhancing data quality through several key initiatives:

- Engaging clinicians to refine documentation and clinical coding.
- Supporting the Mortality Review Group with documentation and clinical coding reviews.
- Continuously validating the recording and coding of patients with Learning Disabilities and/or Autism.
- Providing training and skills updates for both trainee and experienced clinical coders.
- Conducting targeted audits of specialty documentation and clinical coding.
- Addressing data quality issues identified during the coding process by collaborating with the Data Quality Support Team.
- Developing experienced clinical coders to improve staff retention and support broader quality improvement efforts.
- Expanding the use of digital operation notes to enhance the legibility and accuracy of clinical coding.

2.14 Learning from deaths.

In March 2017, The National Quality Board of Directors issued "National Guidance on Learning from Deaths: a framework for NHS Trusts and NHS foundation Trusts on identifying, reporting, investigating and learning from deaths in care". This guidance included the requirements that Trusts must publish a Learning from Deaths Policy, and that from December 2018 Trusts must collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board of Directors Meeting. This data must include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, Trusts must estimate how many deaths were judged more likely than not to have been due to problems in care.

Reducing mortality is a priority for the Trust and is focused through the Mortality Review Group (MRG). The Mortality Review Group performs in-depth investigations using the Structured Judgement Review methodology into groups of patients conforming to agreed criteria as defined within the Trust Learning from Deaths policy.

The Trust currently has 8 trained clinicians who are trained in the Royal College of Physicians Structured Judgment Review (SJR) method for recording deaths, mortality reviews and their outcomes. The Trust has developed an electronic system which logs Structured Judgement Reviews (SJR) electronically and triangulates findings with complaints, claims, inquests, Medical Examiner's Office and clinical incidents. This facilitates richer learning across the Trust.

Mortality Meetings focus upon process and system change, with the aim of developing recommendations to prevent a similar adverse outcome in the future. Any actions and improvements that have been made by the Mortality Review Group are reported to the Patient Safety and Clinical Effectiveness Sub-Committee monthly and the Quality Assurance Committee quarterly.

From 1 April 2024 to 31 March 2025, 243 SJRs were completed. 3 PSII's (Patient Safety Incident Investigation) were carried out in relation to 1253 of the deaths. They occurred in each Quarter of that reporting period as follows:

- Quarter 1 - 54 SJRs completed and 1 Patient Safety Incident Investigation.
- Quarter 2 – 52 SJRs completed and 0 Patient Safety Incident Investigation.
- Quarter 3 - 46 SJRs completed and 1 Patient Safety Incident Investigation.
- Quarter 4 – 91 SJRs completed and 1 Patient Safety Incident Investigation

The Mortality Review Group alongside other modalities provides valuable feedback on all aspects of care and helps us to understand what we may need to improve upon. It also provides the opportunity to identify practice that has been effective and meaningful to our patients. In addition, the Mortality Review Group identify workstreams which ensures the learning is triangulated and themes identified. The Trust publishes their quarterly and annual Report on Mortality Reviews on the Trust's website: https://www.www.nhs.net Board of Directors-meetings-and-papers

2.15 Reporting Against Mandated Core Quality Indicators - Prescribed Information 2024-25.

The 2012 Quality Account Amendment Regulations (10) state that Trusts are required to report against a core set of quality indicators using the following standardised statement set out as follows:

Where the necessary data is made available to the Trust by NHS Digital, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed in the tables below with:

- The national average for the data.
- The NHS Trusts and NHS foundation Trusts with the highest and lowest of the same, for the reporting period.

- Present, in a table format, the percentage/proportion/score/rate/number for at least the last two reporting periods.

Trusts are only required to include indicators that are relevant to the services they provide. Further information on these NHS Digital definitions can be accessed at www.digital.nhs.uk.

2.16 Summary Hospital-Level Mortality Indicator (SHMI).

The data made available to the Trust by NHS Digital is with regard to:

The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period was:

Date Period	Trust	Banding	England Average	England Highest	England Lowest
November 2023 – October 2024	105.13	2	100.36	129.85	69.67
November 2022 - October 2023	92.22	2	100.0	120.65	72.15
October 2022 – Sept. 2023	94.68	2	100.0	122.93	67.70
November 2021 - October 2022	97.41	2	99.93	124.70	62.26
November 2020 - October 2021	98.3	2	100.0	118.60	71.90
November 2019- October 2020	106.9	2	100	117.75	67.82
November 2018 - October 2019	106.89	2	100	120.12	68.48
October 2018 – September 2019	105.93	2	100	118.77	69.79
October 2017 – September 2018	109.92	3	100	126.81	69.17
July 2016 – June 2017	112.32	2	100	122.77	72.61
Data Source: Hospital Episode Statistics (HES) data www.digital.nhs.uk/SHMI *The most up to date data on NHS Digital for the period November 2023 - October 2024 published on 13 March 2025 is displayed.					

NB COVID-19 has been excluded from the SHMI 2020-2021 at a national level by NHS Digital, this is to make the indicator values as consistent as possible with those from previous reporting periods.

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust-level across the NHS in England. This indicator is produced and published quarterly, as an official statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die at the Trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures. A number below 100 indicates fewer than the expected numbers of deaths, and a number above 100 would suggest a higher-than-expected number of deaths.

Trusts are banded 1-3 as follows:

1. The Trust's mortality rate is 'higher than expected'.
2. The Trust's mortality rate is 'as expected'.

3. Where the Trust's mortality rate is 'lower than expected'.

The Trust was categorised 'as expected' over the past 12 months.

Warrington and Halton Teaching Hospitals NHS Foundation Trust intends to/has taken the following actions to improve this rate/number, and so the quality of its services, by undertaking the following actions:

The Trust continues to share learning from the Mortality Review Group using the Mortality and Morbidity (M&M) Meetings which are an opportunity for peer review, collective learning and quality improvement. These are held across all Clinical Business Unit's monthly at the Clinical Business Units Governance Meetings. Mortality and Morbidity Meetings are a professionally accountable forum based on sound educational principles. They encourage openness, honesty and transparency from participants. They focus upon learning and improvement of systems and processes of care and not on individual performance. In addition, please see section 2.14 on Learning from Deaths.

2.17 Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.

Date Period	Trust	England Average	England Highest	England Lowest
01 November 2023 – 31 October 2024	49%	44.65%	66%	17%
01 November 2022 – 30 October 2023	49%	42%	66%	16%
01 October 2022 – 30 September 2023	48%	42%	66%	15%
01 November 2021 – 31 October 2022	46%	41%	65%	12%
01 November 2020 – 31 October 2021	55%	40%	64%	11%
01 November 2019- 31 October 2020	45%	36%	59%	8%
01 November 2018 – 31 October 2019	41%	36%	59%	11%
October 2018 – September 2019	40%	36%	59%	12%
October 2017 – September 2018	34.3%	33.4%	59.5%	14.3%
July 2016 – June 2017	41.7%	31.1%	58.6%	11.2%
Data Source: Hospital Episode Statistics (HES) data www.digital.nhs.uk/SHMI *The most up to date data on NHS Digital for the period November 2023 - October 2024 published on 13 March 2025 is displayed.				

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- This is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data benchmarking system to facilitate further analysis.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate/number, and so the quality of its services, by undertaking the following actions:

- Palliative care coding in the Trust has consistently shown year on year improvement. This reflects increased investment in Palliative Care Services in the organisation alongside increased end of life care education and oversight provided through the Trust's quality structure. This data demonstrates the positive impact of these changes as the increase in palliative care coding reflects improving timely involvement of Palliative Care Services and consideration of palliative care needs at the end of life.
- Clinical Coding attends Mortality Review Group Meetings, which has delivered robust internal palliative care coding training and maintains a monthly validation process to support accurate palliative care data recording for the Trust.
- The validation process has provided assurance that the improvements demonstrated in the data are an accurate representation of palliative care delivery at the Trust.

2.18 Patient reported outcome measures (PROMs) for (i) groin hernia surgery, (ii)* varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery.

Patient Reported Outcomes Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.

***PROMs also exists for varicose vein surgery; however, the Trust does not undertake this procedure.**

This data is made available to the Trust by NHS Digital with regard to the Trust's patient reported outcome measures scores for— groin hernia surgery, varicose vein surgery, hip replacement surgery, and knee surgery, during the reporting period were:

Groin Hernia – Percentage of patients with improvement in EQ-5D health scores			
Year	**Eligible Episodes**	**Trust**	**National Average**
2016/17	100	0.036	0.086
April 2017-September 2017	78	0.019	0.089
2018/19	PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017.		
2019/20			
2020/21			
2021/22			
2022/23			
2023/24			

Varicose Veins – Percentage of patients with improvement in EQ-5D health scores			
Year	**Eligible Episodes**	**Trust**	**National Average**

2016/17	100	0.036	0.086
2017/18	78	0.019	0.089
2018/19	The Trust has not had any eligible patients within PROMS since 2017/18 following the transfer of Vascular Services to Lancashire Teaching Hospitals NHS Foundation Trust.		
2019/20			
2020/21			
2021/22			
2022/23			
2023/24			

PROMS is currently covering 2 surgical procedures for hip and knee replacements; PROMS calculate the health gains after surgical treatment using pre and post operative surveys.

PROMs are collected by all providers of NHS funded care. They consist of a series of questions that patients are asked in order to gauge their views of their own health. Patients are asked to score their health before and after surgery. It is then possible to ascertain whether a patient sees a health gain following their surgery. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs HES data.

Hip Replacement – Percentage of patients with improvement in EQ-5D health scores		
Year	**Trust**	**National Average**
2016/17	0.036	88.2%
2017/18	0.019	89.4%
2018/19	0.500	89.7%
2019/20	0.474	89.4%
2020/21	In order to respond to the challenges posed by the coronavirus pandemic NHS hospitals in England were instructed to suspend all non-urgent elective surgery for patients for parts of the 2020/21 reporting period. A reduced service continued during the 2021/22 reporting period. This has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMS. In addition, it is possible that behaviours around activities relating to the completion, return and processing of pre- and post-operative questionnaires may have also been impacted when compared to earlier years data where behaviours and processes related to managing the current pandemic were not in place.	
April 2021 – March 2022 Finalised PROMs Published: 13 July 2023	0.420	89.8%
April 2022 – March 2023	Insufficient Records available	89.2%
April 2023 -March 2024	0.465	88.1%

Hip Replacement – Percentage of patients with improvement in EQ-5D health scores		
Year	**Trust**	**National Average**
April 2024 – March 2025	HES data is not available for April 2024 - March 2025 PROMs until February 2026	
Data Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms		

Knee Replacement – Percentage of patients with improvement in EQ-5D health scores		
Year	**Trust**	**National Average**
2016/17	0.370	81.0%
2017/18	0.312	82.1%
2018/19	0.324	82.1%
2019/20	0.335	82.8%
2020/21	The Covid-19 Pandemic has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMS. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs HES data.	
April 2021 – March 2022	0.309	87.4%
April 2022 – March 2023	Insufficient Records available	81.6%
April 2023 -March 2024	0.282	80.4%
April 2024 – March 2025	HES data is not available for April 2024 - March 2025 PROMs until February 2026	
Data Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms		

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:

- The PROMs data is a nationally agreed dataset. The data is collected, processed, analysed and reported to NHS Digital by a number of organisations, including hospital Trusts which perform PROMs procedures. PROMs calculate the health gains after surgical treatment, using pre- and post-operative surveys. NHS Digital is responsible for scoring and publishing of PROMs data, as well as linking it to other data sets such as Hospital Episodes Statistics.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate/number, and so the quality of its services, by undertaking the following actions:

- A Trust recovery plan to improve PROMS reporting for 2024/25 continues, and performance will continually be monitored.

2.19 Emergency readmissions to hospital within 30 days of discharge.

The data made available to the Trust by NHS Digital with regard to the percentage of patients aged (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital within 30 days of being discharged from a hospital that forms part of the Trust during the reporting period.

Year	Categories	(0 to 15 (%)	16 or over (%)
2018/19	Trust	10.8	13.0
	England Average	12.3	14.3
	England Highest	86.7	68.8
	England Lowest	1.9	2.7
2019/20	Trust	11.7	13.5
	England Average	12.1	14.2
	England Highest	63.5	50.7
	England Lowest	2.6	4.7
2020/21	Trust	11.2	15.3
	England Average	11.6	15.5
	England Highest	89.3	201.1
	England Lowest	4.9	3.4
2021/22	Trust	11.9	12.9
	England Average	12.1	14.1
	England Highest	57.3	167.4
	England Lowest	3.3	2.8
2022/23	Trust	11.6	14
	England Average	12.8	15
	England Highest	302.9	922.1
	England Lowest	1.9	1.3
2023/24	Trust	10.8	13.9
	England Average	12.4	14
	England Highest	151.7	136.6
	England Lowest	1.3	1.3
2024/25	*Data not yet published by NHS Digital expected November 2025*		
***Data Source**: www. emergency-readmissions*-nhs digital			

Patients aged 0-14				Patients aged 15+			
Discharge period	**Spells**	**Readmitted**	**Readmission Rate**	**Discharge period**	**Spells**	**Readmitted**	**Readmission Rate**
2019/2020	8870	1100	12.4%	**2019/2020**	128740	18400	14.3%
2020/2021	6440	775	12.0%	**2020/2021**	76200	12125	15.9%
2021/2022	7625	940	12.3%	**2021/2022**	84225	11000	13.1%
2022/2023	7690	950	12.4%	**2022/2023**	87915	12980	14.8%
2023/2024	7590	860	11.3%	**2023/2024**	82855	12380	14.9%
2024/2025	Data not yet available until November 2025			**2024/2025**	Data Not Yet Available until November 2025		
Data source: www. emergency-readmissions-nhs digital Data period: Apr-2023 – March 2024 (April 2024 data not yet unavailable as of this data release until November 2025).							

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that the data is as described and available for analysis at the time of writing this report and is influenced by the following:

- The data for both 0-14 and 15+ patients (include readmissions that were for any reason regardless of the original admission reason).
- The figures provided report on all admissions under 15 years of age to the Trust. It is difficult to give an accurate narrative as they consist of all three sites where young people may attend the Emergency Department (ED), assessment or inpatient wards.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate/number, and so the quality of its services, by undertaking the following actions:

- A dashboard was developed during 2024/25 and is utilised for greater analysis with clear outcomes identified.
- In 2025/26 this will continue to be monitored at the Performance Review Meetings.

2.20 Responsiveness to the personal needs of patients.

The data made available to the Trust by NHS Digital with regard to the Trust's responsiveness to the personal needs patients during the reporting period is as follows:

Year	Trust	England Average	England Highest	England Lowest
2015/16	71.7	69.6	86.2	58.9
2016/17	69.5	68.1	85.6	60.0
2017/18	*69.6*	*68.6*	*85.0*	*60.5*
2018/19	*66.5*	*67.2*	*85.0*	*58.9*
2019/20	*68.0*	*67.1*	*84.2*	*59.5*
2020/21	*74.3*	*74.5*	*85.4*	*67.3*
2021/22	*76.0*	*67.1*	*84.2*	*59.5*
2022/23	*Following the merger of NHS Digital and NHS England on 1st February 2023 they are reviewing the future presentation of the NHS Outcomes Framework indicators.* *Proposals for changes to the NHS Outcomes Framework were proposed as part of a wide-ranging consultation on statistical outputs that ran from December 2023 to March 2024. The results of this consultation are now in their final stages of approval. Further announcements about this dataset will be made in due course.*			
2023/24				
2024/25				
Data Source: NHS Digital Outcomes Framework NHS Outcomes Framework Indicators, February 2025 release - NHS England Digital				

Whilst the data for the reporting period has not yet been received from NHS Digital, Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust considers patients' feedback to be pivotal in ensuring our services continue to develop in order to meet individual patient needs. Please note that in 2020/21, changes were made to the scoring regime, so results are not comparable to previous years.

Warrington and Halton Teaching Hospitals NHS Foundation Trust continues to take the following actions to improve the quality of its services, by undertaking the following actions for improvement:

- Friends and Family Test (FFT) scores are reported through the Patient Experience and Inclusion Group at Care Group level. The data is also discussed as part of the Integrated Performance Dashboard monitored at the Quality Assurance Committee, Trust Board of Directors and alongside the Integrated Care Board through the Clinical Quality Focus Group.
- In order to ensure that the Trust is responsive to the needs of patients, families and carers learning is taken from incidents, complaints, claims and PALS to consider further service and care improvement.

2.21 Percentage of staff who would recommend the provider to friends or family needing care.

The data is made available to the Trust by the National NHS Staff Survey Coordination Centre on behalf of NHS England with regard to the percentage of staff employed by, or under contract

to the Trust during the reporting period. This specifies who would recommend the Trust as a provider of care to their family or friends. NHS England took ownership of the NHS Staff Survey, and the indicator was introduced in April 2014. The latest score for the Trust was 58.1%, when compared with other Acute and Acute & Community Trusts, the average median score was 61.5%. It is recognised that the results may be affected by operational challenges and increased patient attendances throughout the financial year however work continues with system partners to improve the position.

The Trust has created an organisational Culture Plan that utilises data from the staff survey as well as other available data to paint a picture of the Trust as a whole, highlighting areas of best practice and opportunities to make improvements, this information is used to target interventions in specific areas of the organisation.

Staff who would recommend the provider to friends or family needing care by percentage*				
Year	**TRUST**	**England Average**	**England Highest**	**England Lowest**
2025	***Currently awaiting national results for 2025 NHS Staff Survey***			
2024	*58.1%*	*61.5%*	89.6%	39.7%
2023	*61.4%*	*63.3%*	88.9%	44.3%
2022*	*55.8%*	*61.9%*	86.4%	39.3%
2021	63.7%	66.9%	89.5%	43.6%
2020	71.3%	74.3%	91.7%	49.7%
2019	65.4%	70.5%	90.5%	39.8%
2018	60.7%	71.2%	90.4%	39.7%
2017	59.5%	70.6%	89.5%	46.4%

Data Source: http:www.nhsstaffsurveys.com/results/

Please note: Figures taken from the Benchmark report are taken from latest available data (2024 survey.)

* The precise wording of the question is '*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'.*

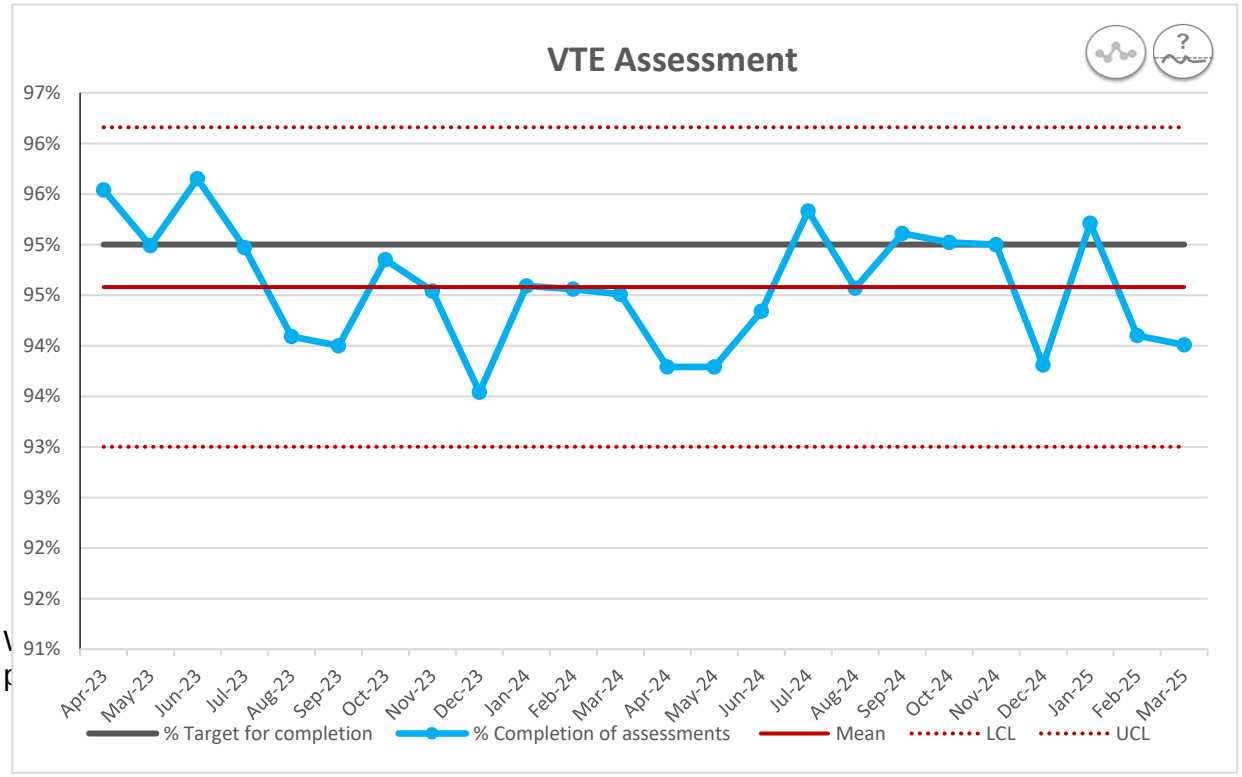
It is also recognised that this report presents the findings of the 2024 national NHS staff survey published on 13th March 2025 which was conducted by Quality Health on behalf of the Trust. Quality Health utilises high quality research methodology and mixed method collection. Results indicate a 51,5% response rate which represents 2409 staff responses.

2.22 Percentage of admitted patients' risk-assessed for Venous Thromboembolism.

The data made available to the National Health Service Trust or NHS foundation Trust by the National Commissioning Board of Directors with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period is as follows:

Percentage of admitted patients' risk-assessed for Venous Thromboembolism				
Year	Q1	Q2	Q3	Q4
2017/18	95.18%	95.88%	95.24%	95.62%
2018/19	95.76%	95.02%	95.03%	95.58%
2019/20	90.45%	90.38%	90.60%	*
2020/21	** Data collection was suspended in March 2020 so figures for Q4 2020 and onwards are not available*			
2021/22				
2022/23	*The VTE Risk Assessment Data Collection will be reinstated from April 2024, with the first submission due in July 2024.*			
2023/24				
2024/25	93.97%	95.00%	94.61%	94.42%

The VTE Assessment graph below shows performance during the reporting period. This was supported by the introduction of a new IT system. Performance is monitored via the Trusts Integrated Performance Report, which is received by the Quality Assurance Committee, Trust Board of Directors and Integrated Care Board.



- This is a nationally accepted dataset which is submitted to the Department of Health at the agreed frequency and performance monitored internally at the Quality Assurance Committee meetings and the public Board of Directors Meetings.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate/number, and so the quality of its services, by undertaking the following actions:

- Non-completion of VTE risk assessments data on GIRFT (Getting It Right First Time) In-patient Ward Productivity Dashboard is projected on ward level e-whiteBoard to encourage the completion of outstanding risk assessments in real time.

- Data provided on the Integrated Performance Report can be drilled down at the ward level daily for identification of these patients and for the ownership of this VTE RA data by clinicians to improve overall compliance.

- VTE Risk Assessments Dashboard is now live on LION Dashboard and access to all Clinical Business Unit Governance Teams has been available since March 2025.

- The Integrated Performance Report can be filtered to Care Group, Clinical Business Unit and to individual ward level. Close monitoring of top ward 5 wards for non-compliance is visible to improve their performance data.

Further improvement actions for VTE RA compliance:

- Monitoring of Clinical Business Unit improvement plans to meet the mandatory target > 95%.

- To inform directly Clinical Lead/Clinical Directors/Clinical Business Unit/Care Group monthly at the end of the month to aim for improvement in respective clinical areas.

- The Thrombosis Group will continue to monitor the data trend for further improvement plans.

2.23 Treating Rate of Clostridioides (Clostridium) difficile infection (CDI) per 100,000 bed days amongst patients aged two years and over.

Healthcare associated infections are monitored monthly on the Trust's Integrated Performance Report, reported to Infection Control Sub-Committee, Quality Assurance Committee, the Trust Board of Directors and the Integrated Care Board.

Data from UK Health Security Agency (UKHSA) on the rate per 100,000 bed days of cases of Trust apportioned *C. difficile* infection (CDI) reported by the Trust for all patients aged 2 and over, for the last four years are shown below. Data for the 2024/25 FY will be included once published.

Rate per 100,000 bed days of cases of Clostridium difficile Infection (CDI) (Trust apportioned cases) amongst patients aged 2 years and upwards				
Year	**Trust** Rate	**England Average for Acute Trusts**	**England Highest for Acute Trusts**	**England Lowest for Acute Trusts**
2024/2025	The data published by **UK Health Security Agency** (UKHSA) will be updated at the end of September 2025 when the latest national data is available			
2023/2024	27.3	27.9	84.9	0.0
2022/2023	27.3	26.9	92.8	0.0
2021/2022	24.5	25.5	78.6	0.0
https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data				

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described as there is a robust system for data entry and validation which ensures that all laboratory confirmed cases for patients aged 2 and upwards are entered onto the UKHSA Data Capture System in line with mandatory reporting requirements.

UK Health Security Agency (UKHSA) have noted an increase in laboratory reported cases of *C. difficile* and has set up a national standard incident to review the situation. Although an increase in Trust apportioned cases was observed, the Trust has remained a low outlier for cases/rates of *C. difficile* infection compared to other northwest Trusts (UKHSA data).

Cases of C. difficile (Trust apportioned cases) amongst patients aged 2 years and upwards are shown in the table below, against the annual thresholds set by NHS England.

Measure	Data Source	**Apportionment**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Trust apportioned number of C. difficile cases	UKHSA Data Capture System	HOHA	34	44	45	66
		COHA	12	11	10	24
NHSE Objective		Threshold	44	37	36	60

HOHA = Hospital onset/healthcare associated
COHA = Community onset/healthcare associated

The Trust took the following actions, which were included in a Brilliant Basics Infection Prevention and Control (IPC) Campaign, to address the rising incidence of *C. difficile*: -

- Introduction of a Trust-wide ward decant and deep cleaning Programme
- Commode spot checks by Matrons
- Pilot of the Well Organised Ward using the 5S Model (with a plan for Trust-wide roll out in 2025/26

- Introduction of Patient Safety Incident Response Framework (PSIRF) and revision to sharing learning from *C. difficile* case with Care Support Worker training Programmes
- An A-Z IPC short message education Programme
- Focus on Antimicrobial Stewardship with the Medical Cabinet
- Focus on use of handwashing sinks for handwashing only

2.24 Patient Safety Incidents.

The data below was made available to the Trust by NHS England with regard to the number of and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Patient Safety Incidents – Rate of incidents per 1000 bed days					
Period	**Trust**	**Trust Number**	**England Median**	**England Highest**	**England Lowest**
April 2024 – March 2025	In September 2023 NHS England paused the annual publishing of this data while they consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the National Reporting and Learning System (NRLS).				
April 2023 – March 2024					
April 2022 – March 2023					
April 2021 – March 2022 NB This is the latest reporting data	35.72	6468	57.5	205.52	23.67
April 2020-March 2021	51.0	8089	58.4	118.7	27.2
Oct 2019 – Mar 2020	44.3	4045	50.7	110.2	15.7
April 2019 – Sept. 2019	48.69	4272	48.5	103.8	26.3
Oct 2018 – Mar 2019	44.68	3964	44.5	95.94	16.9
April 2018 – Sept. 2018	41.6	3833	42.4	107.4	13.1
Oct 2017 – Mar 2018	38.78	3764	42.55	124	24.19
April 2017 – Sept. 2017	41.07	3619	42.84	111.69	23.47
September 2023 update: NHSE have paused the annual publishing of this data while NHSE consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS.					
NB: NRLS Report provided median rate of incidents per 1000 bed days reported by all non-specialist acute Trusts, however, *The NRLS discontinued the use of the large Acute Trust cohort at its publication in April 2015.*					

Patient Safety Incidents Resulting in Severe Harm or Death				
Period	**Trust**	**England National**	**England Highest**	**England Lowest**
Severe Harm and Death April 2024– March 2025	In September 2023 NHS England paused the annual publishing of this data while they consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the National Reporting and Learning System (NRLS).			
Severe Harm and Death April 2023– March 2024				
Severe Harm and Death April 2022– March 2023				
Severe Harm and Death April 2021– March 2022 NB This is the latest reporting data	0.1% (12)	0.2% (Non-specialist acutes only)	0.9% (120)	0% (3)
Severe Harm and Death April 2020 – Mar. 2021	0.1% (16)	0.2% (Non-specialist acutes only)	1.4% (163)	0% (5)
Severe Harm and Death Oct 2019 – Mar 2019	0.2% (9)	0.3% (Non-specialist acutes only)	1.5 (19)	0 (0)
Severe Harm and Death April 2019 – Sept. 2019	0.44% (19)	0.3% (Non-specialist acutes only)	1.6 (58)	0% (0)
Severe Harm and Death Oct 2018 – Mar 2019	0.45% (18)	0.3% (Non-specialist acutes only)	1.8 (42)	0.009% (1)
Severe Harm and Death April 2018 – Sept. 2018	0.73% (28)	0.3% (Non-specialist acutes only)	1.2 (48)	0% (0)
Severe Harm and Death Oct 2017 – Mar 2018	0.37% (14)	0.3% (Non-specialist acutes only)	1.55% (99)	0% (0)
Severe Harm and Death April 2017 – Sept. 2017	0.64% (23)	0.4% (Non-specialist acutes only)	1.98% (121)	0% (0)
NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same Trusts. NB - *National = Severe Harm and Death combined. **NB: NRLS Report provided median rate of incidents per 1000 bed days reported by all non-specialist acute Trusts, however, *The NRLS discontinued the use of the large Acute Trust cohort at its publication in April 2015.***				

Whilst data for the reporting period has not been received as a benchmark comparator at the time of writing this report Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this indicator in terms of the quality of services by:

- Incident data being instantaneously uploaded to the LFPSE service.
- Progress of improvement work identified from a Datix Satisfaction Survey, this actively supporting incident reporting by all members of staff and promoting an open and honest culture.
- Continue to undertake patient safety investigations in line with the Patient Safety Incident Response Policy and Plan.

- Continue to engage meaningfully with our patients, families, and carers to ensure that their voice is included in patient safety investigations
- Continue training for staff to use the Trust's Risk Management System, incident module within Datix.
- Continue training in line with PSIRF Training Needs Analysis
- Continue to monitor actions for improvement consistently, tracking via internal governance processes, ensuring they are completed in a timely manner.
- Additional scrutiny continues at the Trust's Executive Led Safety Oversight Group, chaired by the Chief Nurse.
- Executive led weekly Safety Oversight Meeting members monitor and scrutinises incidents where harm has been caused or any other incidents that may potentially indicate a potential risk to patient safety.

Shared analysis, learning and improvement identified from clinical incidents across the Trust via the following routes:

- Quarterly Governance Reports, including the Learning from Experience Report and Learning from Deaths Report. This is reviewed at the Quality Assurance Committee and Trust Board of Directors.
- Incident, Complaints, Claims and Inquest overview which is reviewed bi-monthly at the Patient Safety and Clinical effectiveness Sub Committee.
- Trust wide safety alerts and notifications.
- Safety briefings in clinical areas.
- Amendments to policy.
- Learning events throughout the year.
- Daily Safety Huddles.
- Trust wide Safety brief.
- Monthly CBU and Specialty Governance Meetings.

2.25 Friends and Family Test Data.

Following a review undertaken by NHS England, the Lead Official for Statistics has concluded that the characteristics of the Friends and Family Test (FFT) data mean it should not be classed as Official Statistics. Therefore, this is no longer included as a core Quality Indicator.

2.26 Freedom to Speak Up (FTSU)

"We consider Freedom to Speak Up (FTSU) in everything we do, all workers will know how to speak up and feel safe doing it. We will become outstanding by listening and learning from our workforce."

In February 2025 the Trust appointed a new FTSU Guardian with protected time for two days. The FTSU Guardian is a full-time employee so can be flexible in the use of the protected time and provide good cover. The Trust has a named FTSU Executive Lead and Non-Executive Lead. In addition, there are now over 50 FTSU Champions from across the Trust representing different backgrounds and professions.

Additional champions are being recruited to further strengthen representation from across the organisation. Workers within the Trust can speak up directly to the Guardian or be sign posted by a Champion; they can text/phone/WhatsApp voice message, email or write to the FTSU Guardian. If details are shared the FTSU Guardian will get in touch with the person raising the issue and offer a face-to-face/teams meeting or the opportunity to discuss further on the phone. The FTSU Guardian will highlight the purpose of the process and advise on what they can do next, the person raising the issue is then supported by FTSU in whatever action they decide to take. FTSU is open to all workers including volunteers, bank and agency workers, students/trainees on placement and contractors working for the Trust.

The Trust has a FTSU Policy which is in line with the national policy stating "If Workers raise a genuine concern (i.e., held in reasonable belief) under this policy, Workers will not be at risk of suffering any form of detriment or losing their job as a result. Warrington and Halton Teachings Hospitals NHS Foundation Trust will not tolerate the harassment or victimisation of anyone raising a concern. Nor will Warrington and Halton Teachings Hospitals NHS Foundation Trust tolerate any attempt to prevent workers from raising any such concern; in fact, any such attempt would itself raise a concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in further action being taken. Warrington and Halton Teachings Hospitals NHS Foundation Trust hope workers will feel comfortable raising a concern openly, but we also appreciate that workers may want to raise it confidentially, and this will be respected.

The Trust FTSU Guardian completes quarterly national returns on activity and reports to the Trust Board of Directors and Strategic people Committee twice a year. The data in the table below shows the number of disclosures raised using the Freedom to Speak Up (FTSU) Guardian and noted reported increase in disclosures year on year.
Table 1 sets out the number of disclosures for the last 3 years and up to Q3 of 2024/25:

Table 1 Number of disclosures

	2021/22	2022/23	2023/24	2024/25
Quarter 1	4	17	6	15
Quarter 2	8	5	6	15
Quarter 3	6	13	9	36
Quarter 4	2	7	10	21
Total	**20**	**42**	**31**	**YTD 66**

The Types of disclosure cases have been grouped and are detailed in the table below:
Table 2 Themes from disclosures.

	2021/22 Q1 – Q4	2022/23 Q1 – Q4	2023/24* Q1 - Q4	24/25* Q1-Q3
Behaviour, culture and relationships	15	31	26	61
Process	2	3	1	
Patient safety/Quality	1	5	7	10
Staff levels / patient care	2	2	1	7

Communication		1		
Worker Safety/Wellbeing			6**	18

*More than one theme can be reported per case
**introduced in Q4 23/24

The number of disclosures is benchmarked against similar Trusts and national guidance is reviewed and implemented. The Trust will be conducting a review in 2025 using the national toolkit provided by the office of the national Guardian. The toolkit review is done every two years.

Freedom to Speak Up continues to be socialised throughout the organisation in order to achieve the described objective as making speaking up everyday business.

2.27 Seven Day Hospital Services (7DS).

The Trust is committed to achieving the standards and continues to implement the priority clinical standards for Seven-Day Hospital Services.

NHS England altered their methodology for assessing compliance with the Seven Day Services priority clinical standards which has allowed the Trust to focus on the Clinical Standard 2 (CS2) of the 7 Day Hospital Services. The standards are: 'Time to First Consultant Review', in Acute Medicine and General Surgery. This means that patients should be seen as soon as possible but within at least 14 hours.

Acute Medicine

The CS2 Acute Medicine initial audit took place in 2019-20 over 2 quarters. The audit findings confirmed that Acute Medicine had a compliance of CS2 at 84% in Quarter 1, and 88% in Quarter 2.

Important considerations as time of audits unknown:

- Query, influence on audit results potentially from; Covid-19 lockdowns, winter pressures, school holidays, new staff rotation including August change over, and annual leave for all MDT
- Can we measure the two forms of data against one another accurately? Due to different times and multifaceted influences on results

The Acute Medicine audit was undertaken in October 2024 to assess sustainability in which the details are outlined below:

Data was collected from the Trust patient record system measuring the time to first Consultant review, extracting documentation which included in the date and time of the post take ward round (PTWR). The data covered the period of 02/09/24 – 08/09/24 and included patients aged 18 years and above and admitted from Acute Emergency Department (AED) under the Acute Medical Team.

73 patients met the inclusion criteria and 63% of those patients had a Consultant review within 14 hours of admission.

The following recommendations have been noted to improve compliance.

- Repeat of clinical audit to assess in real time which will allow the capture of data accuracy.
- Conduct in 2 different quarters to aid comparison.
- Comparison to previous should consider the shifting landscape of Urgent and Emergency care within the NHS pressures.
- Substantive Consultants job plans are under constant review with a forward plan to have 12 hours a day covered by Substantive Acute Medicine Consultants with support from allied professional staffing. The timescale for this is recruitment dependent.

A re-audit has been scheduled to be undertaken in August 2025.

General Surgery

This project reviewed emergency general surgical admissions to hospital and the 1st cycle of this audit was completed in July 2021 showing 77% compliance (Admission to Consultant Review within 14 hours). The 2nd cycle audit completed in February 2022 demonstrated 96% compliance (Admission to Consultant Review within 14 hours). A 3rd audit cycle was completed in 2023 showing 72% compliance. A 4th cycle was undertaken to assess sustainability in which the details are outlined below:

Data was collected from the Trust patient record system measuring the time of referral to the General Surgery Team to the time of the first documented Consultant review. Patients admitted between 02/07/2024 - 09/07/2024 were included. A total of 44 patients were identified and included in the audit.

41 of 44 patients (93%) had a documented Consultant review within 14 hours of admission. The average time to Consultant review was 05:41 hours.
A return to meeting the 90% target is positive and shows that previous recommendations have been effective in restoring our Trust compliance. The following recommendations should continue to be implemented to ensure ongoing compliance:

- Ensure that Consultant review time is documented clearly in the patient notes (especially when documenting retrospectively).
- Ensure that Consultants are made aware of new admissions so that prompt review can be carried out.
- Ensure that new rotating doctors are made aware of the 14-hour target and these recommendations.

A re-audit has been scheduled to be undertaken in August 2025 to ensure compliance above 90% has been maintained.

2.28 Rota Gaps and Plan for Improvement for NHS Doctors in Training.

NHS Organisations under schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps to be included in a statement in the Trust's Quality Account".

We continue to recruit to doctors in training across our Unplanned and Planned Care Groups.

The table below shows the Deanery Trainee gaps on 6 May 2025:

Deanery Trainee gaps		
Care Group	**Grade**	**Number of Deanery Trainee Vacancies**
Planned Care	IMT Gaps	0 (1 IMT2 on maternity leave but is back 05.05.24)
	GPST Gaps	2 in Obstetrics & Gynaecology
	Reg Gaps	1 in Radiology
	Specialist Trainee	1 in Otolaryngology
	Specialist Trainee	1 ST Paediatrics (Trust funded)
	Specialist Trainee	1 ST Surgery (long term sick)
	Reg Gaps - Maternity / Paternity leave GAPs	1 x ST Gastroenterology
		2 ST Surgery
	GPST - Maternity / Paternity leave GAPs	1 x Obstetrics & Gynaecology
Unplanned Care	IMT Gaps	0 (2 in post are 80% LTFT)
	GPST	3 x General Internal Medicine (2 in post are 80%/ 60% LTFT)
		3 x Emergency Medicine
		2 x Acute Internal Medicine
	Reg Gaps	1 x Emergency Department (3 in post are 80% LTFT)
		Acute Internal Medicine 0 (8 in post 80% LTFT)
Clinical Support Services	GP Specialty Training	0

The Trust improvement plan to address rota gaps for NHS Doctors and Dentists in Training is detailed below:

Medical Rota Infrastructure:

- Early identification of gaps from deanery data.
- Implemented of e-rostering for junior doctors.
- General Internal Medicine Resident on call rota generated by grade, within patterns aligning to provide best utilisation of resource

Where Gaps remain, these are mitigated for by the following measures:

- Where gaps occur with short notice, bank and agency junior doctor resource are utilised to maintain safe medical staffing – this remains an option of last choice, with the more sustainable options below being utilised whenever practical.

- Clinical Fellows (CFs) – We continue to recruit to these posts at speciality level, in order to continue to enhance the Multi-Disciplinary Teams at ward level, offering specific experience and research opportunities via fixed term or substantive contracts.

- Trust Grades (TGs) - Recruiting to Trust Grade posts has allowed specialities to provide a senior level doctor in a non-training post within specialities and at ward level. This has enabled us to create additional out of hours support, linked with our General Internal Medicine and surgical specialities rotas.

- Speciality doctors – Recruiting to Speciality Doctors allowed specialities to provide a senior level doctor in a non-training post within specialities and at ward level. Supporting in covering ST3+ gaps within the General Internal Medicine on call rota.

Part 3

Our Quality Improvements and Progress against other Quality Indicators

3.0 Our Quality Improvements and Progress against other Quality Indicators

This section details:

- **A summary of the Quality Priorities agreed for 2025-26.**
- **Details on the Trust's performance on a range of other relevant quality performance indicators and thresholds which have been extracted from NHS nationally mandated indicators and locally determined measures.**
- **Detailed information and commentary on a selected range of improvement areas relating to the three domains of quality: Improve Patient Safety, Improve Clinical Effectiveness and Improve Patient Experience.**

Warrington and Halton Hospitals NHS Foundation Trusts prides itself on being a learning organisation. This is evidenced through an open and transparent reporting culture with clear governance structures to support learning and improvement. The Trust is committed to learning through a range of functions to improve the quality of care that patients receive supported by Quality Improvement methodologies.

3.1 Quality Priorities 2025-26.

Our Quality Priorities chosen for 2025-26 align to the three domains of quality with the Trust. These are detailed below:

2025-26 Quality Priorities

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

The improvement aims	Description of Quality Priorities	The outcome
Improve patient safety	1. Ensure that all patients within the Emergency Department (UEC) receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes. 2. Improve access and productivity in elective care as per national operational planned guidance. 3. We will use quality improvement methods to improve provision of harm free care to our patients with a focus on preventing and reducing harms from pressure ulcers, malnutrition, and sepsis.	**Patient safety is enhanced through a learning culture where quality and safety is everyone's top priority**
Improve patient experience	4. Reduce Health Inequalities inline with CORE20+5 for Children, Adults and Young People. 5. Improve the experience and care provided for patients with a Learning Disability and impaired Mental Health. 6. Implementation of Accessible Information Standard relating to communication and reasonable adjustments to improve Patient Experience	**Practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients**
Improve clinical effectiveness	7. Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIFRT recommendations to support timelier and more effective patient care. 8. Reduce Cancer Waiting Times 9. Improve Theatre Safety Culture using whole quality system approach and robust governance process.	**The quality of the patient experience is at the heart of all we do and 'seeing the person in the patient' is the norm**

3.2 Data Sources.

The Trust compiled a list of potential quality improvement priorities for 2025-26 by:

- Evaluating performance against the quality and safety priorities for 2024-25.
- Evaluating performance against the quality improvement projects undertaken by the Trust.
- Consideration of national and local priorities - agreed with the Integrated Care Board
- Consideration of regulation priorities and Care Quality Commission fundamental standards.
- Areas identified as requiring improvement.

Intelligence information is collated from a variety of sources which can be benchmarked with other organisations. The Trust submits and utilises data from NHS Digital.

The Trust also subscribes to Datix, which is a web-based patient safety software for healthcare management. This enables the Trust to maintain comprehensive oversight of potential risk including incident reporting, complaints, Claims and Patient Advise and Liaison Service information. offering of greater data triangulation.

In addition to this the Trust has invested in a clinically led benchmarking system called Healthcare Evaluation Data (HED), an online solution delivering information, which enables the Trust to drive clinical performance in order to improve patient care.

Other sources of information come from Friends and Family; Inpatient, Outpatient and Staff Surveys and in-house sources including audit and transparency surveys.

3.3 Quality Dashboard.

The clinical indicators in the Quality Dashboard 2024-25 have been reviewed in line with the revised requirements for 2025/26 in relation to the following:

- CQUINs – National (paused at present).
- NHS England KPIs.
- Quality Contract.
- Quality Account - Improvement Priorities.
- Quality Account – Quality Indicators.
- Care Quality Commission.
- Sign up to Safety – national patient safety topics.
- Open and Honest.

This is part of a wider review of quality to align reporting with the committee structure under safety, effectiveness and experience, reporting to the Quality Assurance Committee. The information on this Quality Dashboard is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and improvements are maintained. Since April 2016 the Board of Directors has received an Integrated Performance Dashboard which triangulates quality, access and performance, workforce, and financial information.

3.4 Quality Indicators – rationale for inclusion.

The following section provides an overview of the quality of care offered by the Trust based on performance in 2024-25 against a minimum of 3 indicators for each area of quality namely patient safety: clinical effectiveness and patient experience. These indicators were selected by the Board of Directors in consultation with stakeholders and discussions with the Quality in Care Committee of the Council of Governors. In the main, the Trust has employed indicators which are deemed to be of local and national importance to the quality of care for patients.

The report provides an explanation of the underlying reason(s) for selection and wherever possible we refer to historical data and benchmarked data if available, to enable readers to understand our progress over time and performance compared to other providers. We have also referenced the data sources for the indicators and if applicable included whether the data is governed by standard national definitions.

Where available comparative and benchmarked data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the Trust's local systems.

The improvement priorities and quality indicators were monitored and recorded via the Quality Dashboard and the Improvement Priority quarterly Report reported to the Quality Committee.

Please note where any of these quality indicators for 2024-25 have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they will not be repeated here; only the additional indicators which have not already been reported in Part 2 will be reported here to avoid duplication of reporting.

3.5 Performance against key national indicators.

The NHS Outcomes Framework for 2024-25 sets out high level national outcomes which the NHS should be aiming to improve. The Board of Directors monitors performance compliance against the relevant key national priority indicators and performance thresholds as set out in the NHS Outcomes Framework 2024-25. This includes performance against the relevant access targets and outcome objective and performance thresholds set out in Appendix A of the NHS England's Risk Assessment Framework and Reporting Manual 2023-24 which can be accessed via the following link:

NHS England » Risk assessment framework and reporting manual for independent sector providers of NHS Services

NHS England uses a limited set of national measures of access and outcome objectives as part of their assessment of governance at NHS Foundation Trusts. NHS England uses performance against these indicators as a trigger to detect potential governance issues.

NHS Foundation Trusts failing to meet at least four of these requirements at any given time or failing the same requirement for at least three Quarters will trigger a governance concern, potentially leading to investigation and enforcement action. Except where otherwise stated, any Trust commissioned to provide services will be subject to the relevant governance indicators associated with those services.

Reporting Against Core Quality Indicators sets out the relevant indicators and performance thresholds outlined in Appendix A of NHS England's Risk Assessment Framework. Unless stated in the supporting notes, these are monitored on a quarterly basis.

The NHS Outcomes Framework (NOF) is under review and is part of a wider consultation on statistical outputs. As part of the consultation, it is proposed that only a limited number of NOF indicators will still be published by NHS England on an annual basis. In February 2025, proposals for changes to the NHS Outcomes Framework were proposed as part of a wide-ranging consultation on statistical outputs that ran from December 2023 to March 2024. The results of this consultation are now in their final stages of approval.

3.6 Performance against the relevant indicators and performance thresholds.

WHH aims to meet all national indicators and minimum standards including those set out within the NHS Improvement indicators framework. Performance against the relevant indicators and performance thresholds against national priorities can be accessed via the following link Warrington and Halton Hospitals NHS Trust - Board of Directors Meetings and papers which details the Integrated Performance Report (IPR) and Assurance Committee Reports; which are monitored on a bi-monthly basis at the Public Board of Directors Meetings Part 1.

The Integrated Performance Report includes 76 IPR indicators. The Trust Board of Directors monitors all 76 IPR indicators which have been placed into one of several "Assurance" categories and one of several "Variation" categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count. The Integrated Performance Report and Dashboard has been produced to provide the Trust Board of Directors with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality.
- Access and Performance.
- Workforce.
- Finance Sustainability.

The IPR reports can be accessed via the PDF Web Pack which includes Board of Directors papers for each Board of Directors Meeting via the following link: Board of Directors Meetings and Papers : WHH.

3.7 National Survey Results.

We utilise national survey results to understand the experience of the people who have received care and treatment from the Trust. The National Surveys presents us with contemporaneous data on the experiences of many patients. It is a rich source of information, but viewed alongside the data we gather from complaints, Friends and Family Test data and local surveys.

The National Survey results help us to ensure we direct our improvement efforts towards actions that will have the greatest impact on patients' experience of care and treatment. While clearly there will be standalone 'quick win' actions to take, equally important are the

opportunities to influence our transformation and improvement initiatives by encouraging them to take on Board of Directors insight that the National Inpatient Survey offers us.
You can view our latest National Survey results here:

- https://www.cqc.org.uk/provider/RWW/surveys
- 2023 Adult Inpatient Survey results (published in August 2024)
- 2024 Urgent and Emergency Care Survey results published November 2024 (Emergency Department)
- 2024 Maternity Survey results were published in November 2024

The CQC have publication dates for their surveys which are listed below and can be accessed here: surveys looking at the experiences of NHS patients. The CQC announce the month of publication for each survey one year in advance. The exact publication date is confirmed at least 1 month in advance as outlined below. If a publication date changes, they will explain why.

2024/25 surveys:

- **2024 Community Mental Health Survey:** Published April 2025
- **2024 Maternity Survey:** Published November 2024
- **2024 Urgent and Emergency Care Survey:** Published November 2024
- **2024 Adult Inpatients Survey:** Published August 2024

3.8 Friends and Family.

The NHS Friends and Family Test is an opportunity for patients to leave feedback on the care and treatment that they received at Warrington and Halton NHS Foundation Trust. The feedback is used to review services from the patients' perspective and focus improvements in care.

Friends and Family Test (FFT) surveys now has increased functionality available for patients attending the Trust supporting them to utilise the digital 'Patient Experience Surveys' link to complete their FFT in addition to paper surveys already in place. The benefit of utilising the digital solution includes the use of 'browse aloud' which is an accessibility tool to support people living with a visual or hearing impairment and allows for the survey to be transcribed into other languages or simplified utilising images as well as text. The digital survey can be accessed via the QR code on FFT posters across the Trust or by utilising the link on the paper copies, as well as utilising the Trust website.

If a patient is unable to answer the question, a friend or family member is welcome to respond on their behalf. Users are also asked to rate their responses, and this is translated into a rating which is reported to the Board of Directors.

Friends and Family scores:

Inpatient wards and day case plus Emergency Department:

Users are asked to rate their responses and the results of positive experiences for 2024-25 are detailed in the table below:

The Trust continues to take the following actions to improve response rates, and so the quality of its services, by:

- Continuing to listen to and act on all sources of feedback to review our services from the patients' perspective and enable us to drive improvements in care.
- Continuing to seek opportunities to increase response rates across the Trust and support real time data collection.

Table one below details comparative data in relation to positive recommendation rates.

Table One - Friends and Family Test Positive Recommendation Rates

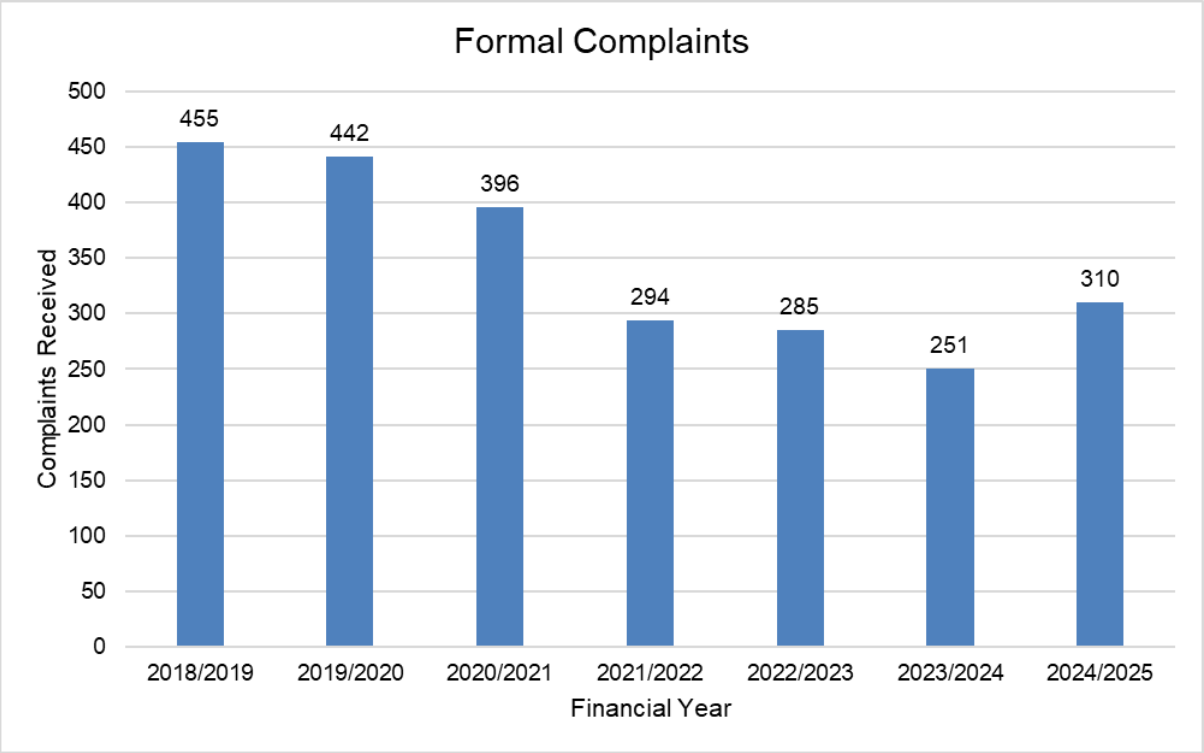
	Inpatients & Day cases			Emergency Department		
Month	**2022/23**	**2023/24**	**2024/25**	**2022/23**	**2023/24**	**2024/25**
April	98%	97%	97%	68%	81%	77%
May	97%	98%	98%	72%	80%	75%
June	97%	98%	96%	70%	72%	78%
July	97%	97%	97%	70%	75%	76%
August	96%	98%	95%	72%	79%	77%
September	97%	96%	96%	71%	78%	78%
October	97%	98%	96%	74%	77%	73%
November	96%	97%	96%	71%	76%	73%
December	95%	97%	98%	66%	73%	72%
January	98%	97%	97%	84%	76%	78%
February	97%	97%	96%	78%	71%	74%
March	96%	98%	Data not yet available	75%	75%	74%

Data Source: The ratings are published on both NHS Choices and in the Open and Honest publication which is published on the NHS England Trust websites.

3.9 Complaints.

The table below details the number of complaints received within the Trust over the year 2024-25. The data demonstrates that the Trust has seen an increase in the number of complaints received from last year with 251 complaints received in 2023-24 compared to 310 complaints received in 2024/25.

The Complaints Policy has been reviewed and revised and is currently going through the Trust ratification process. The expectation is that the number of opened complaints will be reduced, through the proactive intervention the where possible by the Patient Advice and Liaison Service (PALs), with any new complaints to enable the timely resolution of concerns for patients, families /carers.



3.10 Parliamentary and Health Service Ombudsman (PHSO).

The PHSO is a free and independent service. Their role is to investigate complaints where individuals feel that they have been unfairly treated or have received poor service from government departments, other public organisations, and the NHS in England.

Complainants dissatisfied with the Trust's response have the right to ask the PHSO to consider their complaint. However, the complainant must be able to provide reasons for their continued

dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

The PHSO will consider the complaint file, medical records, and any other relevant information as necessary. The PHSO may decide not to investigate further, and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and/or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

The table below details the progress of cases received within the Trust over the year 2024-25. In the year 2023/24 the total number of PHSO cases closed was 2, where 1 was partially upheld and the other was not upheld. In the year 2024/25 a total of 7 PHSO cases were closed, where 3 were upheld, 3 partially upheld and 2 were not upheld.

Content	2021/22	2022/23	2023/24	2024/25
PHSO cases received	2	3	8	2
PHSO cases closed	5	6	2	7
Ongoing PHSO Cases at the end of 2024-25 = 5 Cases				

Content	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
PHSO cases received	1	0	1	0	0	0	0	0	1	4	1	0	0	0	0	0	1	0	0	0	0	1	0	0
PHSO cases closed	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0	0	2	1	0	1	0	0	1	0
Ongoing PHSO Cases at the end of 2024-25= 5 Cases																								

3.11 Patient Stories

Stories of colleagues, patient and carer experiences and journeys enable us to redesign and improve care according to patients' needs, where every step in the patient journey is examined and improved. Stories can provide valuable insights on how we can improve on many different aspects of service delivery and care in our hospitals and in our community-based health care programs. Patient stories are presented across multiple committees and meetings, helping staff to understand and contribute to required improvements and identify good practice for shared learning. Patient stories are available in the public Board of Directors Meeting papers Part 1 which can be accessed via the following link. https://whh.nhs.uk/about-us/how-we-work/Board of Directors-meetings-and-papers/.

Improvements

As a result of feedback received from various methods, examples of improvements are as follows:

Supporting Paediatric inpatients by:

- The introduction of Sophie's Legacy to the Children's Ward supports the Trust to provide nutritious hot meals to parents for when they are unable to leave their children on the wards.
- Introduction of a therapy dog who now visits the Trust on a fortnightly basis
- Charity donations support activity improvements with a new soft play area and gaming carts

Improving our communication with the d/Deaf community; including:

- d/Deaf awareness sessions continued following the success of previous sessions held in 2023 / 2024.
- Trust representatives attended the Warrington Deaf Club to engage with the community and reflect on services provided.
- Twice daily alerts triggered by details recorded within Electronic Patient Records to highlight communication support required.

Addressing comments around signage by:

- Wayfinding and First Impressions Group chaired by Chief Nurse to review wayfinding, signage and communication improvements. Focusing on:
    - Trust wide signage
    - Introduction of digital Information screens

3.12 Patient Safety Incidents.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare. WHH encourages incident reporting and believes that a strong incident reporting culture (i.e., a high level of incident reporting with prevalence of no harm/low harm incidents) is a sign of a positive patient safety culture and provides an opportunity to learn, prevent reoccurrence and improve.

Warrington and Halton Teaching Hospitals, NHS Foundation Trust has a robust process in place to monitor incidents ensuring that learning is identified to support improvements. This includes:

- Patient Safety and Clinical Effectiveness Sub Committee.
- Quality Assurance Committee.
- Integrated Performance Report (reports through to Trust Board of Directors).
- Clinical Business Unit Governance Meetings.
- Care Group Governance Meetings.
- Executive led weekly Safety Oversight Meeting.
- PSIRF Executive- Led Review Group
- Executive weekly dashboard.

There was a total of 10216 patient safety incidents reported in 2024/25. This is a decrease of 178 incidents (1.7%) compared to the previous financial year where 10394 patient safety incidents were reported. Of these incidents in 2024/25; 79% (8086) were no harm, 18% (1875) were low harm, 2% (212) were moderate harm, 0.3% (32) were severe harm and 0.1% (11) were fatal. There were 10 Patient Safety Incident Investigations (PSIIs) identified in 2024/25, which when compared to the total number of patient safety incidents reported equates to 0.1% of the overall figure.

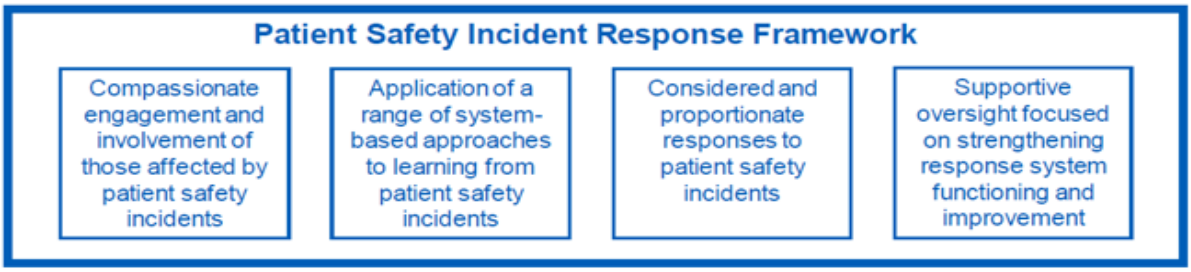
The Trust remains 100% compliant with all Duty of Candour responsibilities.

A quarterly 'Learning from Experience' report is discussed at the Quality Assurance Committee and contains both quantitative and qualitative data analysis, triangulated to demonstrate learning from Incidents, Complaints, Claims, Health and Safety, Clinical Audit, Inquests, Quality Improvement and Research, Compliance and Patient Experience.

3.12.1 Patient Safety Incident Response Framework - (PSIRF) - learning and improving patient safety.

PSIRF was adopted on the 1 September 2023 it is mandated for any organisation who provide funded NHS care. The PSIRF Policy and plan are available on the Trust's website.

- PSIRF replaced the Serious Incident Framework but in itself is not an investigation framework.
- PSIRF aims to support organisations to change culture in order to improve patient safety.
- PSIRF does not mandate investigations as the only method of learning from patient safety incidents or prescribe what to investigate.
- PSIRF aims to move away from targets attached to incident investigations and instead focus on learning and improvement.
- PSIRF moves organisations away from using Root Cause Analysis, to ensure a more system-based approach is adopted.
- PSIRF supports the development and maintenance of an effective patient safety incident response system with four main aims:



The PSIRF Executive Led Review Group considers all information, updates, and shared learning as part of PSIRF to support its ongoing implementation across Warrington and Halton Hospitals (WHH), including high level assurance briefings from the Executive Led Safety Oversight Group.

The Trust Executive Patient Safety Oversight Group has responsibility for overseeing safety processes, to enable assurance to the Patient Safety Incident Response Framework (PSIRF), Executive Led Review Group, that the true intent of PSIRF is implemented, within the organisation, and the Trust is meeting the National Patient Safety Incident Response Framework Standards

The various tools, and Types of investigations and reviews used for learning and improving patient safety include:

- Patient Safety Incident Investigation (PSII) – in-depth review of a single or cluster of incidents to understand what happened and how, and identify learning for improvement to minimise risk of recurrence of such incidents
- Multidisciplinary Team Review – aim is that open discussion to agree the key contributory factors and system gaps that impact on safe patient care and identify learning for improvement to minimise risk of recurrence of such incidents
- Swarm Huddle – initiated as soon as possible after an event and involves MDT discussion. Staff 'swarm' to the site to gather information about what happened and why and decide what needs to be done to minimise risk of recurrence of such incidents.
- After Action Review (ARR) – structured facilitated discussion of an event, based around four key questions, identify learning and actions for improvement to minimise risk of recurrence.

WHH has been using these learning response methodologies (to support incident investigations). These are supported through compassionate engagement with patients, families and staff through direct contact and involvement where appropriate. This approach has also enabled a proportionate response to safety events.

The Patient Safety Incident Response Policy and Plan has been reviewed and revised and is available for all staff on the Trust intranet.

The revised Patient Safety Incident Response Framework Policy and Plan includes additional sections on roles and responsibilities and timeframes for investigation and completion in line with national standards. Revisions also include a Training Needs Analysis, the new meeting /assurance structures and the bimonthly Executive Led PSIRF Group. The revised Policy and Plan were signed off at the Executive PSIRF Meeting in March 2025, and were ratified at the Trusts Policy Review Group in April 2025.Training is being provided to staff to support the PSIRF requirements, and the Patient Safety Training Syllabus and is available through the Electronic Staff Record.

- Mandated Patient Safety Syllabus training figures: Level 1 at 97%, Level 2 at 86% and Senior Leaders at 94%.
- 64 staff have completed HSIB Systems Approach to learning from patient safety incidents training.
- 11 staff have completed the Gateway Training & Consultancy Ltd, Systems Based Approach to learning from patient Safety incidents, with a further 15 staff booked to attend this training in May 2025
- Additional Oversight Training will be delivered by Gateway Training & Consultancy Ltd- (A Systems Approach to Learning from Patient Safety Incidents), during 2025, to further support leadership roles in safety.

- Training for Ensuring, Patient, Family and Staff Involvement in Learning from Patient Safety Incidents for 12 staff will be provided by Gateway Training & Consultancy Ltd on June 19, 2025.

A formal monitoring mechanism (to ensure that Engagement leads, and Learning response leads contribute to 2 or more responses per year) is being developed and will be in place by the end of Q2.

Two Patient Safety Partners are in post and 4 Patient Safety Specialists within the organisation have undertaken the level 3 and 4 Patient Safety Training Syllabus, with Loughborough University. Funding has been agreed for a further 4 members of staff to undertake this training during 2025.

WHHs incident profile has been reviewed and remained significantly unchanged. Following extensive discussions WHH agreed for the local priorities to remain unchanged for a further eighteen months
The 3 local priorities which will be investigated using PSII methodology are:

- Missed or delayed diagnosis of a cancer
- Delay in the identification, recognition and response to a patient's deterioration resulting in delayed escalation and treatment.
- Delay in risk assessment and or management of a patient resulting in delayed treatment (with underlying Mental Health concerns)

3.13 Duty of Candour.

The Care Quality Commission (CQC) introduced the Duty of Candour regulation in November 2015 in line with the Health and Social Care Act 2012. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. - Requirements include informing people about the incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

Statutory Duty of Candour is a legal duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England. All registered providers must demonstrate that they are meeting regulatory requirements to register with CQC and then continue to deliver regulated services. CQC Regulation 20: Duty of Candour, requires that "as soon as reasonably practical after becoming aware of a notifiable safety incident (moderate, severe, prolonged psychological harm for at least a continuous period of 28 days and death) the health service body must:

- Notify the service user/someone lawfully acting on their behalf (the "relevant person") that the event has occurred.
- Provide "reasonable support" to the relevant person.

In relation to WHH internal process, Duty of Candour becomes applicable as soon as a relevant investigation has been declared, as this is when the level of harm associated with the event has been validated.

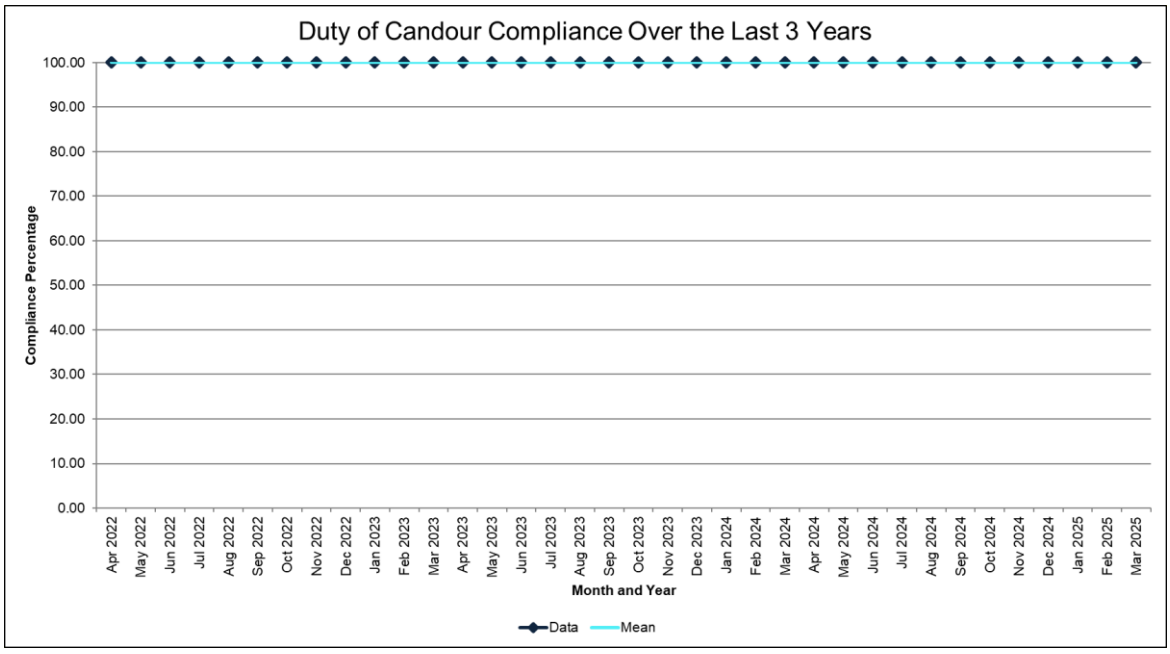
The Trust monitors Duty of Candour at the weekly Executive Led Safety Oversight Meeting, chaired by the Chief Nurse. 100% Compliance with Duty of Candour is consistently achieved. Duty of Candour continues to be reported to the Patient Safety & Clinical Effectiveness Sub-Committee.

For each new Learning Response, a patient or family liaison officer continues to be appointed to provide support and advice. A stand-alone Duty of Candour Policy to support staff with the delivery of Duty of Candour to patients/families of those who have sadly been involved in an incident, resulting in harm has been ratified.

In 2024/25, there were 101 incidents reported with Duty of Candour applied. This is a decrease of 8 incidents compared to the previous financial year.

Duty of Candour					
Financial Year	**FQ1**	**FQ2**	**FQ3**	**FQ4**	**Grand Total**
2020 - 2021	8	24	14	48	94
2021 - 2022	25	34	34	44	137
2022 - 2023	34	39	34	49	156
2023-2024	35	24	25	19	103
2024 – 2025	16	25	28	32	101
Grand Total	102	121	107	160	490

The Trust has achieved 100% compliance with notifying a patient of a verbal and written Duty of Candour (DOC) within 10 working days after becoming aware that a notifiable safety incident has occurred. This is a key focus for each Care Group and associated clinical business unit ensuring that early high-quality conversations with families take place.



3.14 Compliance for Patient Safety Alerts.

Patient Safety Alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients. These alerts are issued by NHS England through the Central Alerting System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages and useful safety information to the NHS and other healthcare organisations.

Patient safety alerts are developed with input, advice and guidance from the National Patient Safety Response Advisory Panel, which assembles frontline healthcare staff, patients and their families, safety experts, royal colleges and other professional and national bodies. The panel discuss and advise on approaches to respond to patient safety issues through the publication of alerts which are identified through the clinical review of incidents reported to the NRLS (now replaced by LFPSE) and Strategic Executive Information System by NHS Trusts and other health care providers and also from concerns raised by members of the public. Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider Programme of work. Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety.

Coordination of patient safety alerts is carried out by the Health and Safety Team who work with various Trust departments and CBUs to facilitate compliance and monitor on-going work or action plans used to address the issues raised.

All of the alerts that Warrington and Halton Teaching Hospitals, NHS Foundation Trust receive are detailed on the CAS email system, as all alerts are not recorded through the CAS web site since 2019 (CHT/2019/001) and 2020 (CHT/2020/002) and 2021 (CH/2021/001 + 002).

To support information (alerts) received, a spreadsheet is maintained where information about each alert is recorded, and evidence of implementation and actions taken to ensure compliance is recorded in Datix. The following tables provide information on the alerts received by each month and financial year.

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
2019-20	6	7	7	11	3	7	21	16	14	12	21	15	140
2020-21	20	14	10	14	11	13	6	11	14	5	15	9	142
2021-22	6	4	10	7	8	9	7	15	13	8	16	9	112
2022-23	6	13	6	6	6	5	9	14	5	8	6	10	94
2023-24	4	8	2	9	9	8	2	3	9	5	8	5	72

2024-25	**8**	**8**	**7**	**11**	**9**	**6**	**13**	**7**	**7**	**5**	**4**	**9**	**94**
Grand Total	**50**	**54**	**42**	**58**	**46**	**48**	**58**	**66**	**62**	**43**	**70**	**57**	**654**

National Patient Safety Alerts Financial Year / Month													
Type of Alert	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
2021-22	0	1	3	1	3	0	0	1	0	0	0	2	11
2022-23	1	1	1	0	2	0	1	2	0	2	1	0	11
2023-24	0	3	1	2	1	2	0	1	3	2	2	0	17
2024-25	2	3	0	2	0	1	2	0	1	0	0	1	12
Grand Total	3	8	5	5	6	3	3	4	4	4	3	3	51

1. The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information to the NHS and others, including dependant providers of health and social care.

2. Trust policy: *Central Alerting System (CAS)* Policy, sets out how received alerts will be processed through the Trust, administration for dealing with safety alerts it through the Trust's nominated CAS Liaison Officer (CASLO) who is responsible for cascading alerts to the relevant groups and individuals (a role associated with the Health and Safety Department).

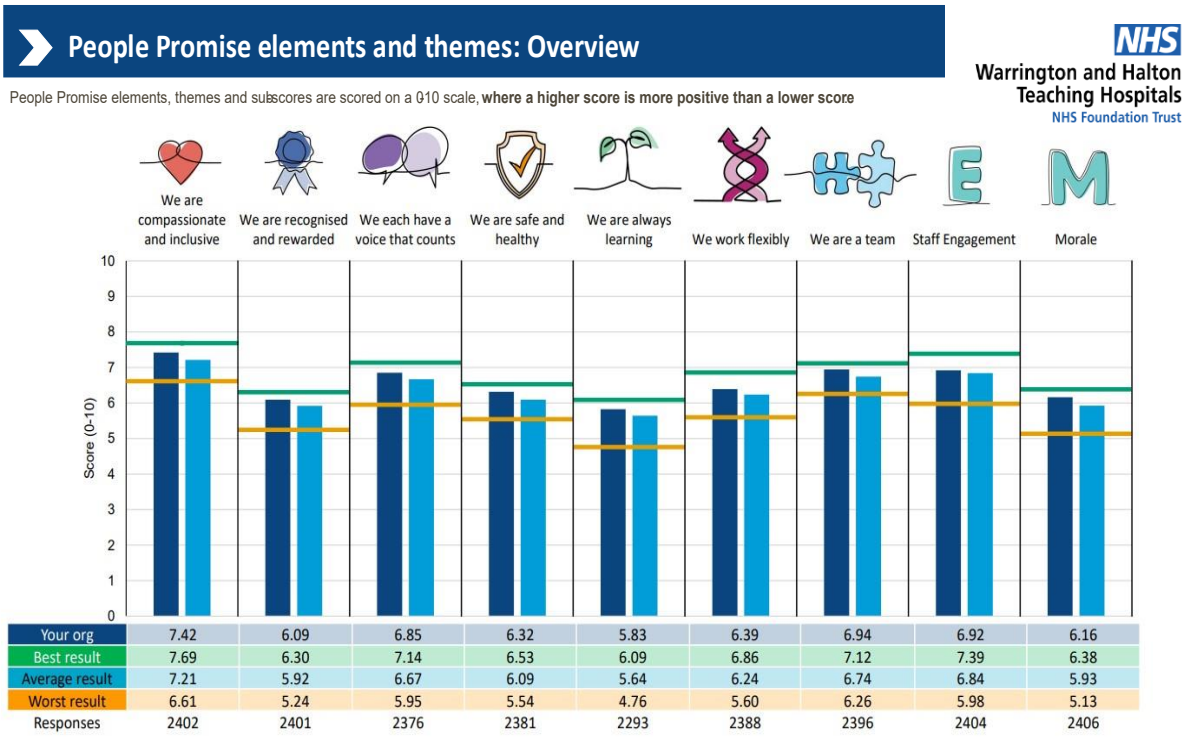
3. Distribution and closing of alerts are overseen by the Head of Health and Safety, and monitoring of compliance is undertaken through the Health and Safety Subcommittee, with an Executive lead.

4. Where necessary for an alert such as a National Patient Safety Alert (NatPSA), as required distribution will also include an executive lead with oversight of the project related to the needs of the alert, to completion of all actions and closure to the Central Alerting System (CAS) website.

3.15 Staff Survey Results.

All NHS Trusts are required to survey their workforce annually using the National Staff Survey. The survey comprises around 100 questions. The NHS England benchmark reports are themed in line with the nine elements of the survey, including the NHS People Promise and two themes of 'Staff engagement' and 'Morale'.

People Promises and Themes in the 2024 Staff Survey	
People Promise (PP) / Theme (T)	**Sub-score / Theme**
We are compassionate and inclusive (PP)	• Compassionate culture • Compassionate leadership • Diversity and equality • Inclusion
We are recognised and rewarded (PP)	• Not applicable
We each have a voice that counts (PP)	• Autonomy and control • Raising concerns
We are safe and healthy (PP)	• Health and safety climate • Burnout • Negative experiences
We are always learning (PP)	• Development • Appraisals
We work flexibly (PP)	• Support for work-life balance • Flexible working
We are a team (PP)	• Team working • Line management
Staff engagement (T)	• Motivation • Involvement • Advocacy
Morale (T)	• Thinking about leaving • Work pressure. • Stressors (Health and Safety Executive Index)
Data Source: NHS People Plan – published 2023: www.england.nhs.uk/ournhspeople/	



The most updated results from the 2024 NHS Staff Opinion Survey results for the themes of "We are Compassionate and Inclusive" and "We are Safe and Healthy" are as follows:

We are compassionate and inclusive

WHH scored 7.42 for this theme overall which is higher than comparator organisations of 7.21 but is 0.05 lower than the Trusts 2023 score of 7.48. For question 15 "Does your organisation act fairly with regards to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age" the Trust scored 61.24% compared to the Acute Trust average of 56.02%. The Trust is above the national acute Trust average, however, recognises the importance of ensuring equity in relation to progression and promotion.

has a Workforce Equality, Diversity and Inclusion Strategy (2022-2025), which has an annual refresh of workplans, and priorities based on the staff survey intelligence. In addition, the We are WHH: Culture Plan, utilises the survey data as a metric for targeting support in the right services across the Trust.

Additionally, there are specific action plans in place aligned to the Workforce Race Equality Standard and the Workforce Disability Equality Standard to continue to improve the experience of our workforce in relation to acting fairly in terms of career progression or promotion irrespective of protected characteristic. This is reported through our Strategic People Committee on a bi-annual basis to ensure monitoring of improvements and that actions meet targeted deadlines. More information about this can be found on the Trust website.

Aligned to the introduction of the NHS Equality, Diversity and Inclusion Improvement Plan in June 2023, further work will be completed based on the results of the 2024 survey to ensure that disparities experienced by certain protected characteristics are addressed.

We are Safe and Healthy

The Trust scored 6.32 for this theme which is higher than the comparator score of 6.09 and slightly below the best scoring organisation in this Category who achieved 6.53.

In relation to harassment, bullying or abuse at work:

- Question 14b asks "How many times have you personally experienced harassment, bullying or abuse at work from managers?" The Trust scored 7.62% which is a slight deterioration from the 2023 score of 7.42% and lower than the comparator Trust score of 10.00%.
- Question 14c asks "In the past 12 months how many times have you personally experienced bullying, harassment, or abuse at work from other colleagues?" The Trust scored 16.38% which is a slight deterioration from the 2023 score of 15.93% but still remains lower than the national median at 18.49%.

There remains further work to do in this area focused on the disparities experienced by certain protected characteristics. This is monitored through the Workforce Inclusion and Culture Sub-Committee, chaired by the Chief People Officer.

The organisational Programme of kindness, civility and respect continues which has been integrated with the Patient Safety Incident Response Framework (PSIRF) program of work to effect organisational cultural change. In addition, this intelligence feeds into the We are WHH: Culture Plan which focuses on ensuring that everyone has "a good day at work".

3.16 Ockenden Report.

All Trusts were required to reassess their position against the 15 Immediate and Essential Safety Actions recommended following the publication of the Ockenden Report Part 2 on 30th March 2022. The Women's and Children's CBU Governance Meeting considered the Trust's position against these recommendations and a monthly update report has been presented to the Quality Assurance Committee (QAC) and to the Trust Board of Directors.

The Maternity Team have focused on implementing the actions from the Ockenden Report with assurance of completion evidenced within three action plans:

- Ockenden Part 1a developed following release of the first report.
- Ockenden Part 1b following receipt of the Trust Provider Report of Ockenden 1a evidence. submitted.
- Ockenden Part 2 following the launch of the second report.

Following a robust review and assurance process all Ockenden action plans were assessed as fully compliant in July 2024. A final review of the Ockenden action plan was completed by the Women's & Children's CBU quadrumvirate and the action plans were closed down. This was

reported to and noted by Trust Board of Directors in December 2024. All activity related to Ockenden actions is now managed as part of the service's business as usual processes.

3.17 Healthcare Associated Infections.

A summary of mandatory reportable Healthcare Associated Infections (HCAI), numbers of cases for 2024/25 is included in the table below.

The numbers include hospital onset/healthcare associated and community onset/healthcare associated cases that are apportioned to the Trust.

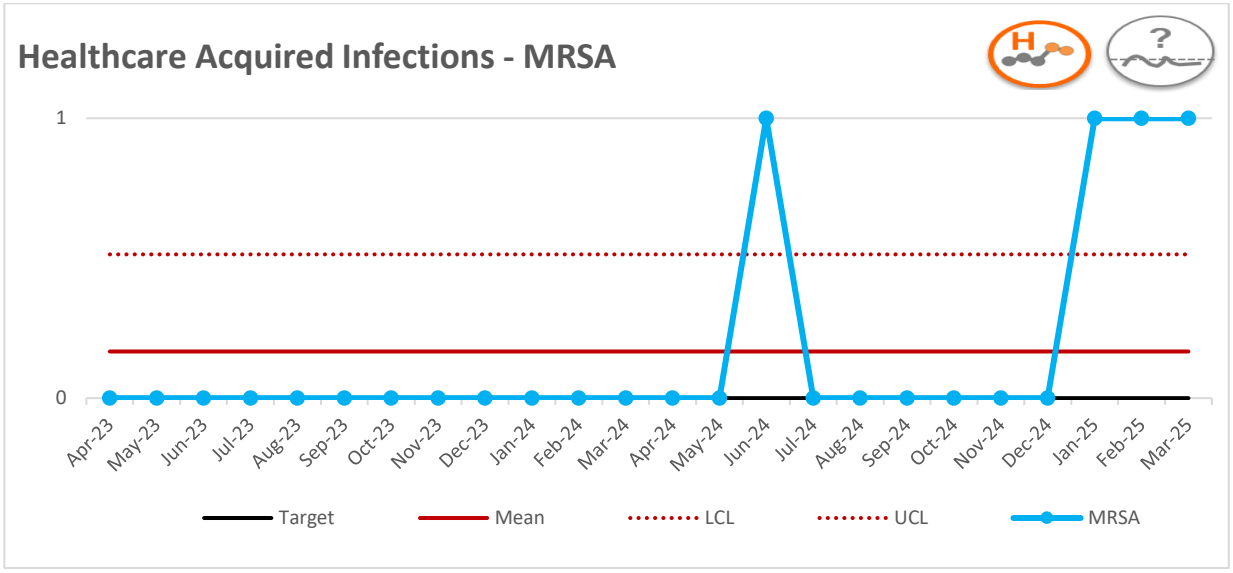
Mandatory Reportable Healthcare Associated Infections (HCAI)				
	Trust Apportioned Cases 2021-22	**Trust Apportioned Cases 2022-23**	**Trust Apportioned Cases 2023-24**	**Trust Apportioned Cases 2024 -25**
Meticillin-Resistant Staphylococcus aureus (MRSA) bacteraemia	1	3	0	4*
Meticillin-Sensitive Staphylococcus aureus bacteraemia (MSSA) *	29	21	36	34
C. difficile	46	55	55	90
E. Coli Bacteraemia	63	67	81	89
Klebsiella Spp. Bacteraemia	26	23	28	30
P. aeruginosa Bacteraemia	3	4	11	10

***Meticillin-resistant Staphylococcus aureus* (MRSA) bacteraemia**

There is a zero tolerance to avoidable MRSA bacteraemia cases. During the 2024/25 financial year (FY), 4* Trust apportioned MRSA bacteraemia cases were reported. This was an increase in cases, following a 22-month period with no MRSA bacteraemia cases.

Following a review with Cheshire and Merseyside Integrated Care Board of Directors, one of the cases was apportioned to a neighbouring healthcare provider, leaving 3 cases attributed to this Trust.

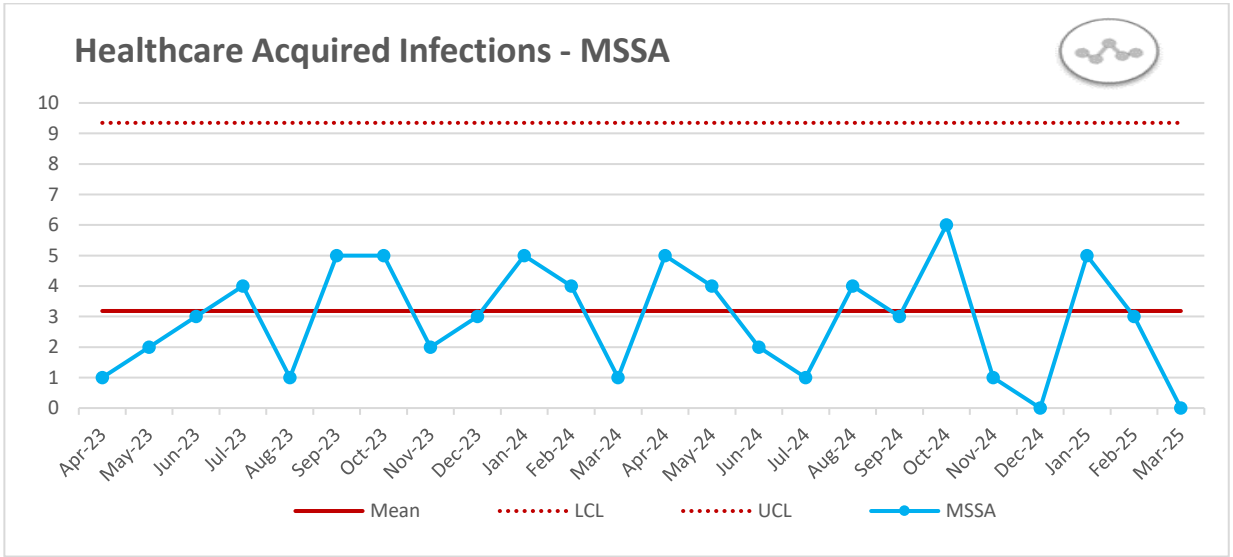
Graph 1 shows the results for MRSA bacteraemia cases in 2024-25.



***Meticillin-sensitive Staphylococcus aureus* (MSSA) bacteraemia**

During the 2024/25 FY the Trust reported 34 Trust apportioned cases of MSSA bacteraemia. This was a decrease of 2 cases compared to the previous financial year. There is no set threshold for MSSA bacteraemia cases. Some of these cases were associated with deep seated infections that could not be prevented. An action plan is in place to prevent MRSA/MSSA bacteraemia cases. This focuses on compliance with MRSA admission screening, education on use of aseptic non-touch technique, auditing practice standards for care of invasive devices and sharing learning from incidents.

Graph 2 shows the results for MSSA bacteraemia cases in 2024-25.

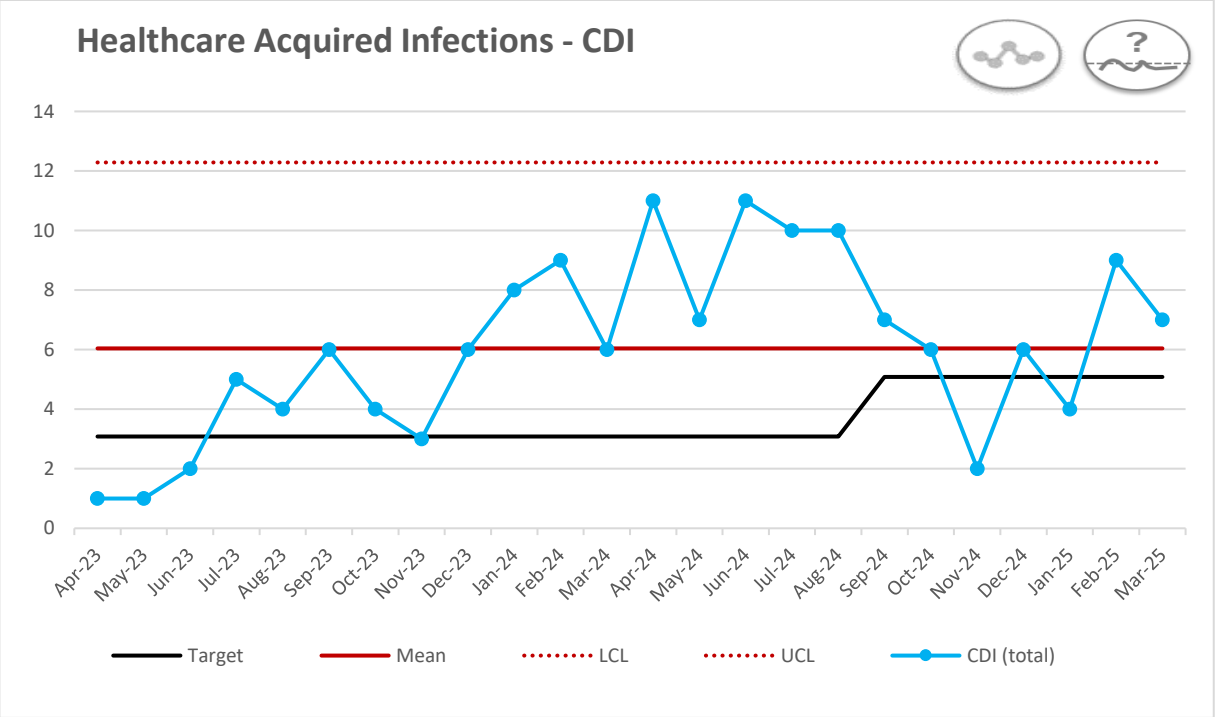


Clostridioides (Clostridium) difficile (*C. difficile*)

During the 2024/25 FY the Trust reported 90 Trust apportioned cases of *C. difficile* against the annual threshold of 60 cases. This is an increase by 35 cases compared to the previous financial year.

There is an action plan in place to prevent cases of *C. difficile* which focuses on antimicrobial stewardship, environmental hygiene, hand hygiene, surveillance to detect cases, compliance with the SIGHT mnemonic (suspect, isolate, gloves and aprons, handwashing and toxin testing) and learning from incidents. A review of patients with recurrent infection has commenced to identify any points for learning. The Trust exceeded the annual threshold (60 cases) by thirty cases. Despite the increase in cases compared to the previous financial year, regional HCAI data shows the Trust is a low outlier for *C. difficile* compared to other acute Trusts in the northwest region.

Graph 3 shows the results for Clostridium Difficile Infections (CDI) cases in 2024/25.



Gram-negative Bloodstream Infections (GNBSI)

Within the National Action Plan on confronting antimicrobial resistance (2024/29), an aim has been set to prevent any increase in Gram-negative bloodstream infections (GNBSI) from the 2019/20 financial year baseline. This is a revision to the previous 50% reduction target, and this was implemented following recognition of challenges linked to an aging population with comorbidities and anticipated increase in incidence of GNBSI. It has also been noted that there is limited evidence in the literature for interventions which work to prevent GNBSI. GNBSI include: -

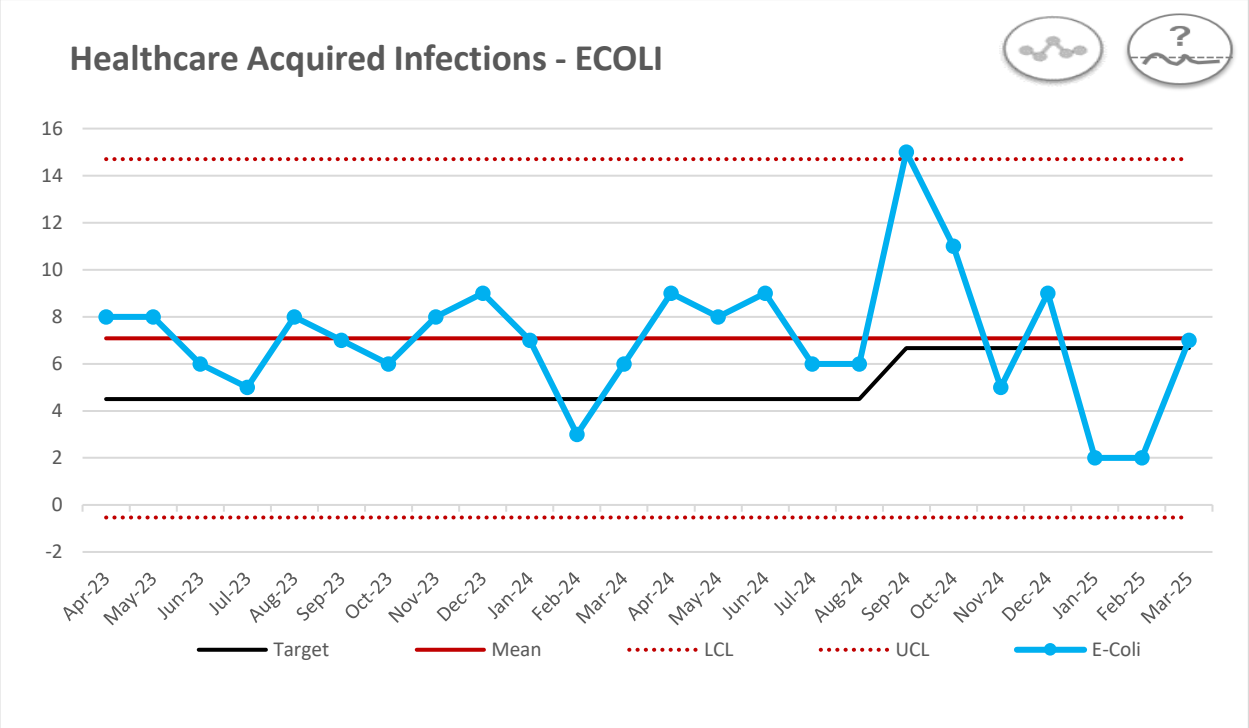
- *E. coli*
- *Klebsiella spp.*
- *Pseudomonas aeruginosa*

A breakdown of Trust performance for each GNBSI is detailed below.

***E. coli* Bacteraemia.**

The Trust reported 89 Trust apportioned cases of *E. Coli* bacteraemia during the FY. This is an increase of 8 Trust apportioned cases compared to the previous year. The Trust exceeded the set threshold (79 cases) by 10 cases.

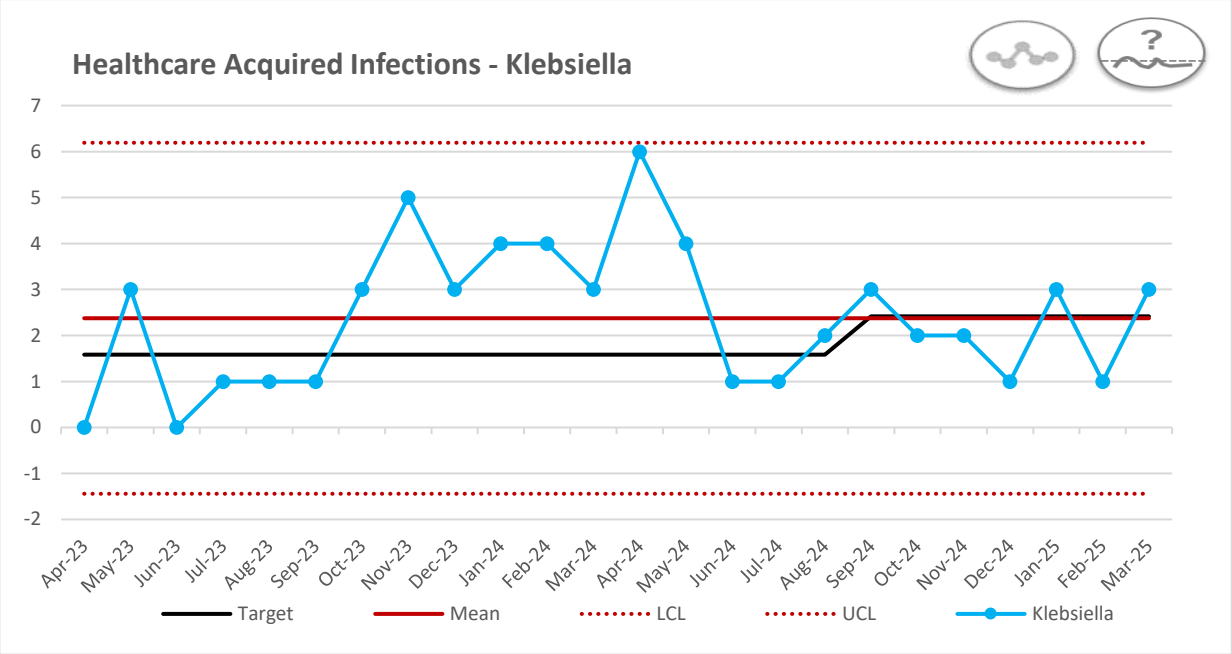
Graph 4 shows the results for E Coli Bacteraemia cases in 2024/25.



***Klebsiella spp.* Bacteraemia.**

The Trust reported 30 Trust apportioned cases of *Klebsiella spp.* bacteraemia during the FY. This is an increase of 2 Trust apportioned cases compared to the previous year. The Trust exceeded the set threshold (28 cases) by 2 cases.

Graph 5 shows the results for Trust Apportioned Klebsiella spp. Bacteraemia Cases in 2024-25.

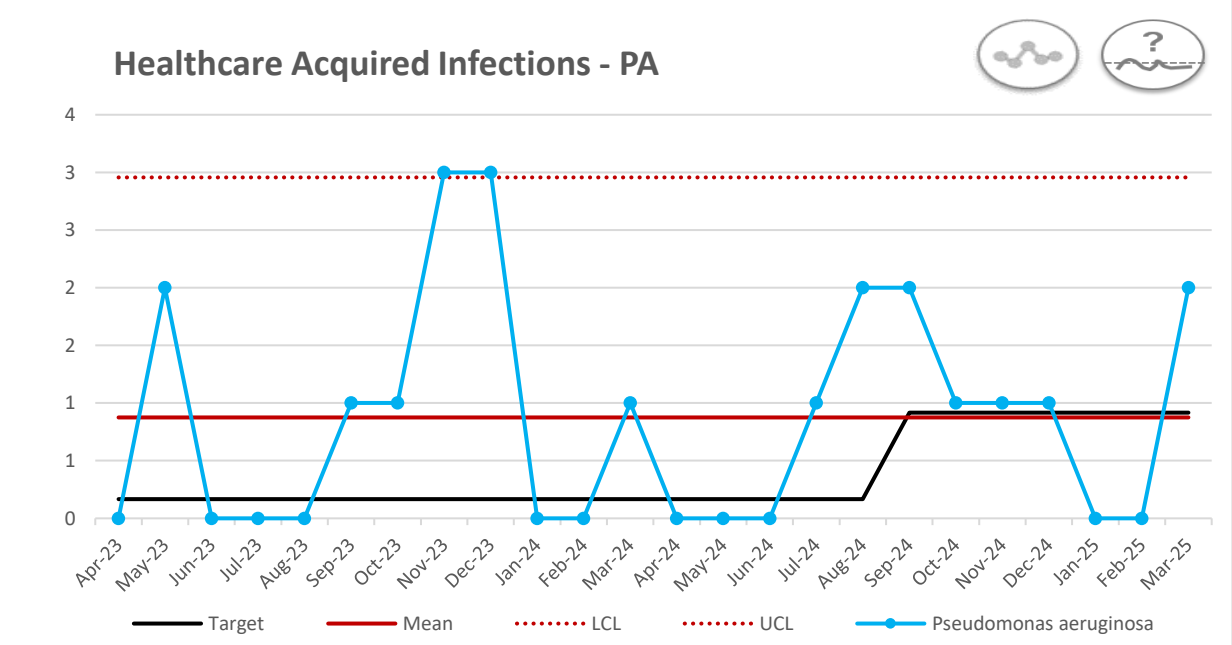


***P. aeruginosa* Bacteraemia.**

The Trust reported 10 Trust apportioned cases of *P. aeruginosa* bacteraemia during the FY. This is a decrease of 1 case compared to the previous year. The Trust stayed below the national threshold (10 cases) for P. aeruginosa bacteraemia.

Partnership working is in place across the health economy and the Trust is working with both internal and community partners to progress action plans to prevent GNBSI.

Graph 6 shows the results for Trust Apportioned Pseudomonas Aeruginosa Bacteraemia cases in 2024-25.



The Quality Committee has a process to undertake 'deep dives' in order to provide a detailed evaluation of specific issues within the Trust. The deep dives aim to provide assurance on actions in place and provides opportunities to discuss key issues. Deep dives were submitted to the Quality Assurance Committee on: -

- GNBSI in April 2024 - the most likely source of these infections was associated with the urinary tract, followed by hepatobiliary (liver, bile ducts and / gallbladder). Activity is in place to prevent urinary tract infections, and a repeat audit of the hepatobiliary cases is planned
- *C. difficile* in September 2024 - *C. difficile* remains a national and local priority with an aim to reduce Trust rates of infection in line with the national and local objectives. The deep dive showed good compliance with the antibiotic formulary for treatment of *C. difficile* cases

How progress will be monitored, measured and reported

- Continuous monitoring of Trust healthcare associated infections and patient outcomes with mandatory reporting to UKHSA
- Review and updates to action plans to prevent: -
    - Methicillin resistant *Staphylococcus aureus* (MRSA) and Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia cases
    - *C. difficile* cases
    - Gram-negative bloodstream infections (GNBSI)

- Focus on best practice and learning from investigation of mandatory reportable HCAI aligned to the Patient Safety Incident Response Framework
- Review of UKHSA reports on national increased incidence of *C. difficile*
- Infection Prevention and Control Sub Committee monthly
- Patient Safety and Clinical Effectiveness Sub-committee monthly
- Quarterly Director of Infection Prevention and Control Report presented to the Quality Assurance Committee showing in year progress on activity

The Trust will continue to work with system partners to improve infection prevention and control practice and reduce HCAI across the wider healthcare economy and comply with the Code of Practice on prevention of Healthcare Associated Infections and the Board of Directors Assurance Framework.

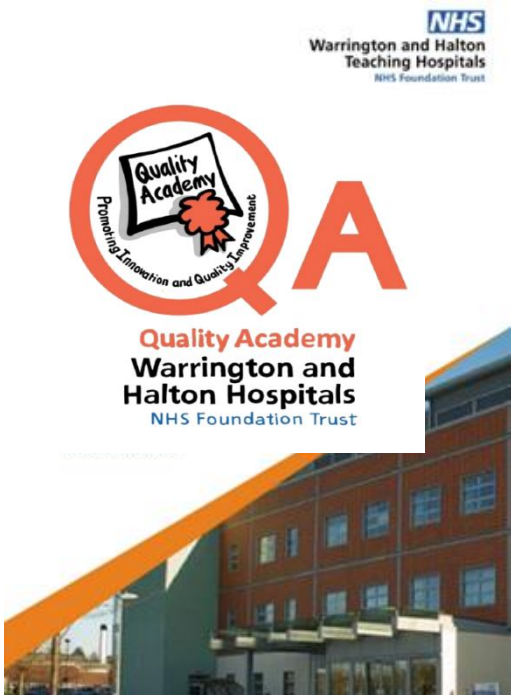
3.18 Quality Academy Overview.

The Quality Academy (QA) was established in 2018 as a vibrant centre of inquiry, bringing together our Clinical Audit, Continuous Quality Improvement, Knowledge and Evidence Services and Research, Development and Innovation teams. The Quality Academy promotes innovation and improvement and is part of an enabling arm to deliver the Trust Quality Priorities.

Objectives.

WHH Key priorities for the Quality Academy are:

- To support the delivery of the Quality Priorities.
- Work collaboratively with other services across the Trust to embed and sustain continuous improvements.
- Develop a learning culture of continuous quality improvement within the Trust.
- Develop training programs including training in Quality Improvement Methodology and other QA work streams.
- Support to move toward best practice with use of Data and Evidence Services.
- Support Programmes of work, alongside system partners to sustain and optimise clinical improvements.



Engagement.

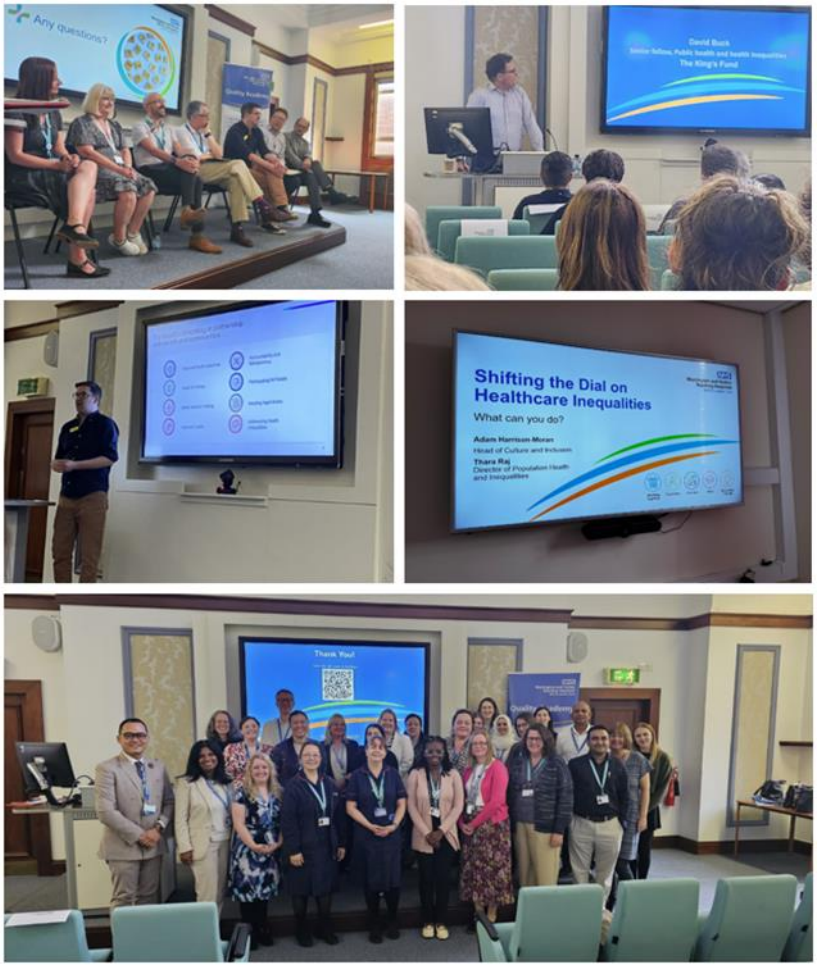
It is key to ensure that we are listening to our stakeholders and addressing what matters to them. The Quality Academy actively seeks, listens, and acts on feedback received from patients, the public, staff and groups such as Governors, Health Watch and Health Scrutiny Committees. The academy supports work undertaken by all teams across the organisation including Communications and Engagement, Patient Experience and Workforce and Organisational Development. The Quality Academy continue to work closely alongside the Advancing Quality Alliance (AQuA) and Health Innovation Northwest Coast (formerly the Innovation Agency).

Quality Academy Showcase.

Each year the Quality Academy hold celebration and learning events and one of the main highlights is the Quality Academy Showcase. The teams in the academy work alongside internal and external partners to deliver a learning and networking event to share the latest knowledge in research, innovation, learning from evidence-based practice, clinical audits, and improvement in healthcare. The event is a unique opportunity to celebrate success, bring teams together and highlight the exceptional work of our colleagues.

This year the event focussed on the theme of healthcare inequalities and patient and public involvement, with expert keynote speakers Olly Benson (NHS England) and David Buck (The King's Fund), highlighting the message that everyone should have a voice in the care they provide and receive. A series of breakout sessions focussed on how we as a Trust and local community can make this a reality and improve the quality of care that we provide, for all. A series of oral and poster presentations also put the spotlight on outstanding project examples demonstrating how our staff deliver safe, effective, and compassionate care with a focus on continuous improvement.

Figure 1: Pictures from the 2024 Quality Academy Showcase



3.19 Quality Academy: Continuous Quality Improvement (CQI).

The Continuous Quality Improvement (CQI) Team aims to improve quality of care and staff experience through the application of QI methodologies. The drivers that have underpinned this aim this financial year are:

1. Supporting high impact Trust wide improvement projects
2. Developing CQI systems and processes
3. Developing our culture for continuous improvement

3.19.1 Supporting high impact Trust wide improvement projects

The central CQI Team works collaboratively with clinical, Operational and Transformation Team colleagues to support the delivery of strategic improvement priorities. In the past year, this has included:

Emergency Department (ED) Triage and Streaming

Significant and sustained improvements in the average time from arrival to Triage, and the percentage of patients Triaged within 15 minutes of arrival to ED, were observed following the implementation of the Manchester Triage System (MTS) in April 2024. MTS is an evidenced based Triage system that is used widely in the NHS. The CQI Team has provided advice and guidance on the use of QI methodology and QI tools to support project groups within this workstream, supporting with the presentation and interpretation of data to effectively evaluate the impact of changes implemented and further steps required. QI work is ongoing to make further process improvements within Triage in both ED and SDEC.

Frailty Assessment Unit (FAU) improvement

An independent diagnostic study completed in December 2023 identified our Frailty Assessment Unit as one of 4 streaming pathways where opportunities existed to help alleviate pressure on our ED. This QI project undertook a systematic analysis to understand FAU processes and capacity, to identify a sustainable approach to maximise the efficiency and quality of the service, whilst supporting patient flow. Several tests of change were introduced resulting in an increase in the average number of patients seen by the FAU daily.

Reducing late starts to Theatre lists

At Warrington and Halton Hospitals, 70.6% of elective Theatre sessions start late* (data from April to August 2024). This contributes to poor Theatre utilisation, with associated financial implications and leads to on the day cancellations and long waiting lists where a patient's condition may deteriorate, impacting on their quality of life and creating a poor patient experience. The CQI Team has supported efforts to fully understand the root causes of late starts using methods such as process mapping, time and motion study, waste analysis. An action plan and PDSA cycles have been developed to test out improvements such as the implementation of a forward wait area, and changes to staff activities and roles in supporting the preparation of patients for Theatre.

Improving ward length of stay (LOS)

Average LOS on one of our general medicine wards is currently 11.1 days, showing a year-on-year increase of 1.8, 0.6 and 0.5 days respectively from 2021-2024. This is higher than the regional average of 10.4 (Model Health Systems, Nov 2024). A reduction in average LOS will support bed availability and increase the number of possible daily admissions, supporting the wider Trust to create capacity to provide essential inpatient care and relieving pressure on ED outflow. The CQI Team is working with the Clinical Team to complete a stakeholder analysis and process mapping to fully understand ward and discharge processes in order to identify opportunities for reducing length of stay and facilitating earlier discharge where appropriate.

Increasing utilisation of the Discharge Lounge

Use of the Discharge Lounge for medically optimised patients waiting to leave hospital can help hospital flow by creating additional bed capacity earlier in the day. Utilisation of the discharge lounge has seen significant and sustained improvement over the past year but baseline data

analysis and engagement with stakeholders by the CQI Team support further efforts to increase the number of patients transferred there.

Reducing the incidence of postpartum haemorrhage (PPH)

A Quality Improvement Project Group was formed with the aim to reduce the occurrence of PPH at WHH. Through the application of QI methodology, inconsistencies in the recognition, recording and learning from PPH occurrences were identified and change ideas identified.
The learning and ideas generated were shared regionally and have contributed to the development of new regional guidelines for PPH management, including for example 1) weighing of swabs at set intervals 2) revised risk assessment processes and 3) bespoke treatments management for women triggering risk factors.

DrEaMing (Drinking, Eating and Mobilising post-surgery)

The DrEaMing QI project was initiated as part of a national improvement collaborative to ensure patients are Drinking, Eating and Mobilising within 24 hours of surgery. Led by a team within the Planned Care Group, this project focused on patient awareness and engagement with their post operative elective recovery from pre op through to post op care on Captain Sir Tom Moore site and A5 elective wards. The team completed seven PDSA cycles to identify successful ways of involving patients in the DrEaMing initiative, including involving patients in the design and testing of the patient questionnaire, patient information leaflet and poster. Data showed increasing numbers of patient questionnaires being completed month on month. Patients are reporting confidence in their involvement in DrEaMing as part of their surgical care post operatively and some examples of patient feedback are provided below.

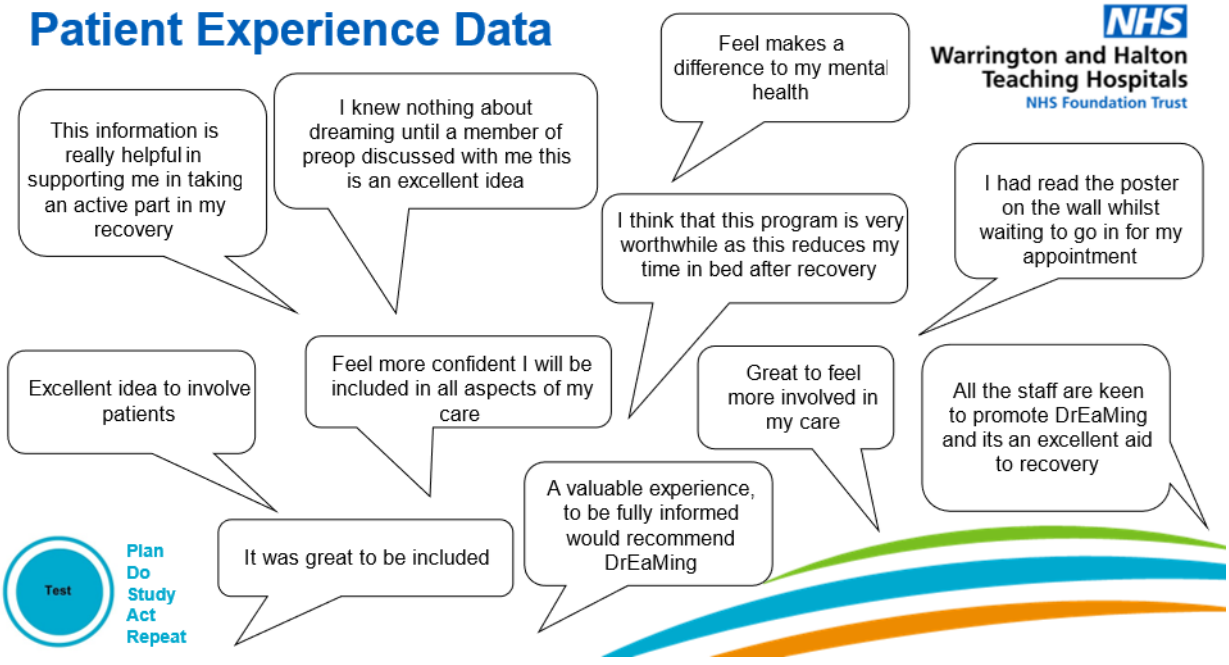


Figure 1 Patient feedback from the DrEaMing project

3.19.2 Developing CQI systems and processes

Building Improvement Capability and Capacity

The CQI Team deliver a Programme of internal training to support Trust staff to gain the knowledge and skills required to deliver QI projects in their own areas. In line with the NHS Impact (Improving Patient Care Together) recommendations, in 2023-24 we committed as an organisation to build a foundation of six levels of CQI capability (see figure 2 below), targeted to the role that each staff member plays in supporting our culture for improvement. The training ranges from level one (an introduction to QI) to level 6, which is represented by our Expert Faculty. Key progress in 2024-25 includes:

1) A new level 1 Introduction to Quality Improvement E-learning course has been developed with input and feedback from our Quality Improvement Practitioner Community. This is a self-paced course, taking approximately 30-40 minutes to complete was launched in November 2024. It is accessible via ESR and can be undertaken by any staff member at any convenient time.

2) The CQI Team has been successful in achieving accreditation from the RCN for the Level 2 Foundation and Level 3 Practitioner Training.

3) Five delegates from planned, unplanned, corporate and Clinical Support Care Groups successfully completed training through NHS Elect Coach Development Programme in September 2024 to become Quality Coach Trainers. The Quality Coaches have since been working to adapt the Programme content and structure to best fit future delivery in-house, with the intention to launch Level 4 training in 2025-26.

4) A QI Competency and Training Framework has been developed to underpin Level 6 expert faculty, and the QI Team have completed a baseline assessment to establish development requirements.

Figure 2

Training Delivery and Evaluation

In the past year we have increased the number of staff who have completed Level 2 foundation training by 57% and the number who have completed Level 3 QI practitioner by 42%. Figure 3 below outlines the number of staff who have completed Level 2 and 3 training.

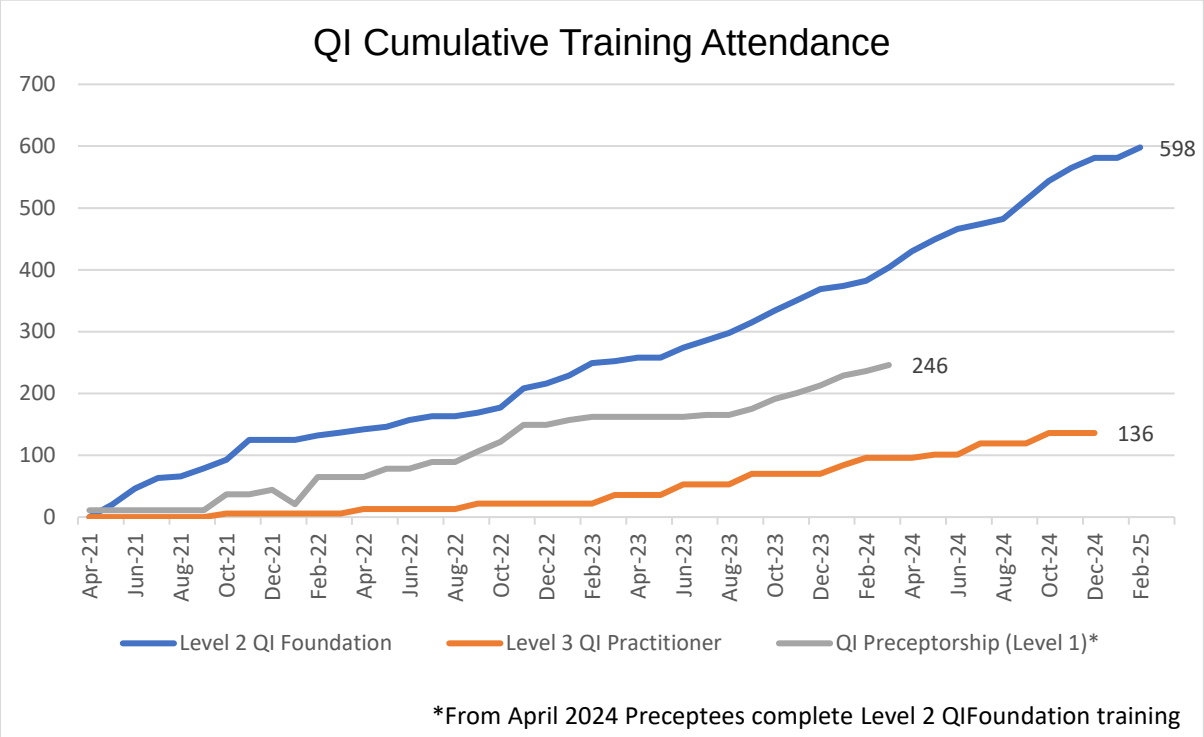


Figure 3 The number of staff trained over time in the QI Foundation, Practitioner and Preceptorship Programme.

WHH collect and review feedback following each training session delivered to ensure that we continuously learn and improve the training we provide to ensure we meet the needs and expectations of participants to deliver QI work. The average quality score (on a scale of 0-10) for Level 2 Foundation and Level 3 Practitioner course is currently 9.2 and 8.8 out of 10 respectively. To measure the impact of Level 3 QI Practitioner training, we ask participants on a scale of 1 – 10 how confident they were to lead a QI project, both before and after the training. Figure 4 demonstrates the significant increase in confidence on completion of the training across cohorts.

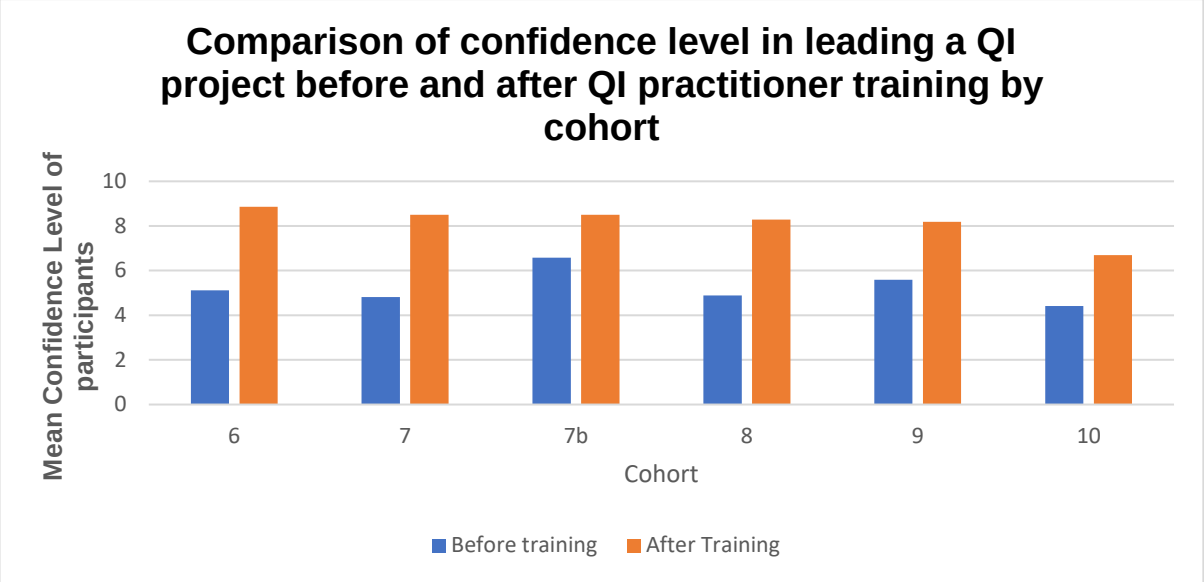


Figure 4 Comparison of confidence level in leading a QI project before and after QI practitioner training.

Local Quality Improvement Projects (QIPs)

Teams across the Trust are encouraged to develop their own QIPs to make improvements in their local areas. We continue to refine and improve our internal processes to support the use of robust QI methodology throughout the organisation and drive sustained improvement.
Local QI initiatives and projects that have been completed have highlighted the following achievements over the course of the financial year:

- Increase utilisation of the Virtual Frailty Ward (VFW) – Increased the frequency with which at least 80% of VFW capacity was utilised from 8.3% to 38.9%.
- Improved management of alcohol withdrawal in the Emergency Department – sustained increase in usage of the Alcohol Pathway and referrals to Alcohol Liaison Team.
- Improved compliance for continuous fetal monitoring during labour improving patient safety for both mum and baby.
- Reduction in Controlled Drug (CD) administration incidents - achieved a 30% reduction in CD administration incidents through tests of change involving single point lessons and changes to the layout of CD cupboards.
- Improved recruitment time to hire - demonstrated a reduction in annualised Time to Hire from 145 days to 49 days, with additional benefits including vacancies filled more quickly, resulting in reduced bank and agency spend backfilling gaps and an improved experience for candidates
- Improved completion of staff declarations of competency to use medical devices - from 47% in February 2024 to 74% in November 2024. Improved compliance supports patient safety by providing assurance that staff are adequately trained and competent to use medical devices and can identify potential gaps in training.
- Improved quality of communication of out of hours tasks to allow more appropriate prioritisation of activities.

3.19.3 Building and sustaining a culture of continuous improvement

Quality Improvement Dashboard

To help improve oversight and governance of local quality improvement work, we have developed a Quality Improvement dashboard. This enables Care Groups and CBUs to access up to date information at any time, including the number of staff who have completed QI training and details of registered QI projects in each area.

Quality Improvement Practitioner Community (QIPC)

WHH have continued to build our Quality Improvement Practitioner Community, hosting three events in this financial year. The aim of QIPC is to offer group coaching and support, provide an avenue for sharing learning, reaching out for support or guidance, and developing the skills to support QI further within the Practitioners field of work.
Since the launch event in October 2023, QIPC has achieved the following:

- Co-production of the Five Essentials of Continuous Quality Improvement concept and branding
- Co-production of a revised QIP registration form
- Sharing success and learning from others with QIP presentations
- Liberating Structures workshops
- Coaching development workshops
- Feeback and development of Level 1 Introduction to QI e-learning
- Co-production of the QIPC mission statement

'We will build a QI community, forming a social movement to build capacity, energy and motivation for all staff to make improved, sustained change.'

Improvement Excellence Celebration Events

We continue to run quarterly Improvement Excellence events attended by Executive Directors to recognise and share the successes of staff completing Level 3 QI Practitioner training, and those who have completed QIPs that have achieved our certification criteria or the criteria for meeting a standard of excellence in QI.

Image 1: Staff attending the December QI Excellence Celebration Event

Shared Learning Forum (SLF)

To further develop a culture of learning and improvement, a Shared Learning Forum (SLF) was launched in February 2024 with an aim to provide an opportunity for WHH colleagues, partners, and people with lived experience of our services to share, learn and engage in interactive activities. Two SLFs have taken place in the past year, sharing learning on the following topics:

- Improved care for patients with fractured bones
- Learning from the maternity Triage department
- Learning from ACP development
- Learning from Interventional Radiology Improvements
- Freedom to Speak Up
- Learning from addressing Health Inequalities

Annexes

Annex 1: Quality Account Statements

Statements from Integrated Care Board of Directors (ICBs), Local Healthwatch Organisations and Local Overview and Scrutiny Committees and other stakeholders 2024-25 are presented within this document unedited by the Trust and are produced verbatim.

Integrated Care Board have assumed responsibilities for the review and scrutiny of Quality Accounts and will now be requested to provide a statement on the Quality Accounts. (Integrated Care Board of Directors (ICBs) replaced Clinical Commissioning Groups (CCGs) in the NHS in England from 1 July 2022).

NHS England clarifies that Foundation Trusts are only required by regulation to share their Quality Report with NHS England or relevant ICBs (as determined by the NHS (Quality Accounts) Amendment Regulations 2012), local Healthwatch Organisations and Overview and Local Scrutiny Committees.

The NHS Cheshire and Merseyside Integrated Care Boardhave assumed responsibilities for the review and scrutiny of Quality Accounts, and to key stakeholders as part of the regulatory requirement and consultation process and feedback is noted within the ICB letter including:

- Integrated Care Board (ICB)
- Healthwatch
- Overview and Scrutiny Committee

There is no regulatory requirement for Foundation Trusts to share their Quality Account/Report with Health and Wellbeing Board.

Statement from the NHS Cheshire and Merseyside Integrated Care Board (ICB) on the Quality Account

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

NHS
Cheshire and Merseyside

Ref: Warrington and Halton Teaching Hospitals NHS Foundation Trust

NHS Cheshire and Merseyside ICB
No1. Lakeside
920 Centre Park Square
Warrington
WA1 1QY

13 June 2025

Sent by email to:
Ali Kennah, Chief Nurse
alison.kennah@nhs.net

Re: 2024/25 Quality Account Statement

Dear Ali

NHS Cheshire and Merseyside Integrated Care Board (ICB) have worked closely with Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) throughout 2024/25 and recognise the achievements made with regards to quality throughout the year.

With regards to 2024/25 achievements, we note the opening of the new endoscopy hub at Halton Hospital which offers additional diagnostic and screening ability for patient across Cheshire and Merseyside. We congratulate the Trust on receiving the recognition for the high quality of their maternity services. We recognise the Trusts commitment to continuing the CQUINs from 2023-24 to promote continuous quality improvement despite the national pause for 2024-25. The planned garden balcony for patients on the intensive care unit is really compassionate and will support patients and families during a difficult time, we look forward to hearing about its progress in the 2025/26 account.

The achievements against the identified quality priorities have been built on significant work, the culture shift and systems thinking that is described as PSIRF embeds is commendable, this is reflected in the applaudable MIAA audit results. The improvements made to support more efficient and effective patient care are really positive, they are a brilliant example of improving efficiencies without increasing spend.

The improvements made for patients with mental health challenges across A&E and inpatients are encouraging, in terms of patient experience and supporting the discharge pathway. We will be working with WHH throughout 2025/26 to support completion of the remaining target areas, for example in relation to the challenges around category 2 pressure ulcers and the gaps in knowledge of practice, this would be beneficial to work together at a system level and we support this priority being continued into 2025/26.

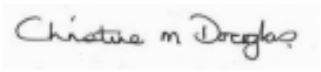
NHS
Cheshire and Merseyside

The Trust active clinical audit programme and use of appropriate data collection has been described within the account and assures oversight of clinical effectiveness and continuous review. The improvement journeys described around care at the end of life, diabetes, emergency laparotomy and dementia are positive. We will work closely with the Trust to understand more of the clinical audit findings requiring action during 2025/26 and support this delivery to allow further improvement journeys to be presented in the next quality account.

The Trust's open learning culture is evident in the account, which outlines a number of learning opportunities, as well as effective practice, that have been identified in relation to mortality. We will again work closely with the Trust to oversee the improvements made against these learning points.

Finally, it is recognised that the individual effort of staff and teams within the Trust make a huge impact to patient care. This is strongly recognised within the account through the highlighted achievements and patient feedback. We also recognise the ongoing progress being made with the recent recruitment to the Freedom to Speak Up Guardian and additional champions to strengthen the provision across the Trust.

Yours sincerely



Chris Douglas MBE (she/her)
Executive Director of Nursing & Care
NHS Cheshire and Merseyside ICB

cc.Kerry Lloyd, Denise Roberts

NHS Cheshire and Merseyside
No 1 Lakeside, 920 Centre Park Square
Warrington, WA1 1QY

Communications@cheshireandmerseyside.nhs.uk
Cheshireandmerseyside.nhs.uk

Statement from the Trust's Council of Governors on the Quality Account

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2024/2025.

The Quality Account is detailed and thorough and assists the Governors in holding the Non-Executive Directors to account for the performance of the Board of Directors.

One of the Governors prime roles is to focus on quality. As part of the Trust's governance structure, Governors meet regularly with the Chair of the Trust and NEDs. Governors receive the latest performance information and have the chance to analyse and raise questions. Governors observe each of the Trusts board committees including the Quality Assurance Committee. The allocated Governor Observer reports to the CoG on the effectiveness of the NED in the role of Chair at each meeting including but not limited to the Chair's ability to challenge and seek assurance during committee meetings.

The formal Council of Governors meetings are open to members of the public to observe. The Governors have several sub committees and groups which they participate in including the Patient Experience and Inclusion subcommittee, which allows them to bring information and views from their constituents to the attention of the Board.

The Governors strongly support the emphasis on patient safety, patient experience and clinical effectiveness documented throughout the Quality Account.

For the coming year 2025/26, the Governors agree with the priorities established and have had presentations during the formulation of the priorities.

The Patient Safety Priorities relating to:

1. Ensure that all patients within the Emergency Department (UEC) receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes.

2. Improve access and productivity in elective care as per national operational planned guidance.

3. We will use quality improvement methods to improve provision of harm free care to our patients with a focus on preventing and reducing harms from pressure ulcers, malnutrition, and sepsis.

Clinical Effectiveness Priorities regarding:

4. Reduce Health Inequalities inline with CORE20+5 for Children, Adults and Young People.

5. Improve the experience and care provided for patients with a Learning Disability and impaired Mental Health.

6. Implementation of Accessible Information Standard relating to communication and reasonable adjustments to improve Patient Experience

The Patient Experience Priorities relating to:

7. Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIFRT recommendations to support timelier and more effective patient care.

8. Reduce Cancer Waiting Times

9. Improve Theatre Safety Culture using whole quality system approach and robust governance process.

The Governors are assured that the 2024/25 Quality Account provides data that is meaningful, understandable, and clear to all. The report shows indicating trends, and comparisons with the previous year statistics.

Governors find the format and section headings helpful. The Quality Account contains considerable detail corresponding with the complex and diverse range of services provided by an Acute Hospital.

The Council of Governors believe the Quality Account to be accurate, the data and accompanying explanations support members of the public to understand clearly the progress made in many areas of patient safety and patient care.

Governors encourage all Trust members, members of the public and others who are interested in the performance of our hospitals to read the Quality Account.

Sue Fitzpatrick

Lead Governor – Warrington and Halton Teaching Hospitals NHS FT

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Joint statement from Healthwatch Halton and Healthwatch Warrington on the Quality Account

Nik Khashu
Chief Executive Officer
Warrington Hospital
Lovely Lane
Warrington
WA5 1QG

30 May 2025

Dear Nik

Re: Quality Account report 2024 - 2025

We hope all's well with you.

We welcome the opportunity to comment on Warrington and Halton Teaching Hospitals NHS Foundation Trust's Quality Account for 2024–25. Based on what local people have told us, we feel the report accurately reflects patients' and their families' experiences. Most people we heard from reported positive experiences, praising the friendly staff and the dignified care they received. The Quality Account echoes these positive views and also recognizes areas needing improvement (such as waiting times and communication). Despite positive feedback, some basic aspects of care and access have not been as positive:

- **Communication at Discharge:** Patients and carers often feel unprepared for discharge due to a lack of information or support (for example, one patient was sent home at night without transport). This aspect of care needs to be improved.
- **Waiting Times:** We heard about excessive waits in A&E and months-long delays for specialist appointments. Providing timely care is a basic expectation that still needs attention.
- **Accessibility and Facilities:** Patients raised frustrations with parking, wheelchair availability, and signage. At Halton, others had long phone waits to book blood tests and unclear appointment letters. These may seem minor, but they greatly affect patient experience and need addressing.

The Quality Account shows that the Trust fosters a learning culture, using patient experiences to drive improvement. During the past year we have found the Trust to be open and responsive to issues raised by Healthwatch. For instance, when Healthwatch Warrington highlighted Deaf patients' communication difficulties, the Trust swiftly developed an action plan to improve accessibility. Likewise, after our joint report called

for better hospital discharge processes, the Trust worked with partners on an action plan to address our recommendations. We believe the Trust is clearly listening and learning from what people say, which is encouraging.

The three quality objectives are ambitious and will hopefully drive improvement. We note the report reviews progress against last year's goals and sets clear targets for the coming year. We appreciate that the report provides data showing how improvements are measured and tracked, making accountability easier. We would still like to see a simple "achieved"/"not achieved" status for each of last year's targets to make progress even clearer, but overall the monitoring approach is clear and results are presented well.

Patients have consistently told us that staff are kind and respectful. We applaud the Trust's partnership approach: its quick actions on issues like support for Deaf patients and improving discharge show a strong focus on patient-centred care. Moreover, patient safety and clinical outcomes have been maintained at good standards.

We feel the Quality Account aligns well with what patients and carers have told us, and the Trust is quite candid about where improvements are needed and proactive in learning from feedback. We feel confident the new quality priorities will drive positive change.

We thank the Trust's staff for their dedication and look forward to continuing our close partnership to ensure patient voices remain heard.

On behalf of Healthwatch Halton and Healthwatch Warrington, we would like to pass on our thanks and appreciation to everyone at the Trust for their dedication and hard work on behalf of our communities during the past year. We look forward to continuing our close partnership to ensure patient voices remain heard.

Kind regards

Dave Wilson

Dave Wilson
Chief Officer - Healthwatch Halton

Lydia Hughes
Chief Officer – Healthwatch Warrington

Statement from Warrington Overview and Scrutiny Committee on the Quality Account

Noted within the ICB statement letter following presentation with all key stakeholders.

Statement from Warrington Health and Wellbeing Committee on the Quality Accounts

Noted within the ICB statement letter following presentation with all key stakeholders.

Statement from the Halton Health Policy Performance Board of Directors on the Quality Accounts

Noted within the ICB statement letter following presentation with all key stakeholders.

Annex 2: Statement of directors' responsibilities for the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust Board of Directors on the form and content of Annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust Board of Directors should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 and supporting guidance.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board of Directors minutes and papers for the period 1 April 2024 to 31 March 2025
    - Papers relating to Quality reported to the Board of Directors over the period 1 April 2024 to 31 March 2025.
    - Feedback from Cheshire and Merseyside Integrated Care Board dated 13/06/2025
    - Feedback from Council of Governors dated 10/06/2025
    - Feedback from local Healthwatch organisations, Healthwatch Halton and Healthwatch Warrington dated 30/05/2025
    - Feedback from Overview and Scrutiny Committee dated 13/06/2025
    - Feedback from Halton Borough Council dated 13/06/2025
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16/06/2025
    - The 2024 national NHS staff survey published 13/03/2025

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Report has been prepared in accordance with the Quality Accounts regulations and guidance as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board of Directors

Nikhil Khashu
Chief Executive

Steve McGuirk
Chair

Annex 3: Independent Auditor's Assurance Report on the Annual Quality Report

The Quality Accounts are no longer required to undergo an independent review and NHS providers are not expected to obtain assurance from external auditors on their Quality Account.

The accounts will continue to be shared with key Stakeholders for external scrutiny and comment.

Annex 4: Glossary of Abbreviation and Definitions

Abbreviations	Definitions
Appraisal	Method by which the job performance of an employee is evaluated
Care Quality Commission (CQC)	Independent regulator of all Health and Social Care Services in England. They inspect these services to make sure that care provided by them meets national standards of quality and safety.
Clinical audit	Is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical Commissioning Group (CCCG)	Clinical Commissioning Groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS Services in England.
Clostridium difficile (C diff)	A Clostridium difficile infection (CDI) is a Type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital. (CMCLRN) Cheshire and Merseyside Comprehensive Local Research Network
Commissioning for Quality and Innovation (CQUIN)	This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Friends and Family test (FFT)	Since April 2013, the following FFT question has been asked in all NHS Inpatient and A&E departments across England and, from October 2013, all providers of NHS funded Maternity Services have also been asking women the same question at different points throughout their care: "How likely are you to recommend our [ward/A&E Department/Maternity Service] to friends and family if they needed similar care or treatment?"
Gram-Negative Bloodstream Infection (GNBSI)	A laboratory confirmed bloodstream infection with a bacteria that can cause serious illness.
Governors	Governors form an integral part of the governance structure that exists in all NHS foundation Trusts; they are the direct representatives of local community interests in foundation Trusts

Abbreviations	Definitions
Healthwatch	Healthwatch is a body that enables the collective views of the people who use NHS and Social Care Services to influence policy.
Healthcare evaluation data (HED)	Clinical benchmarking system to support clinical experts in more effective management of clinical performance.
Hospital episode statistics (HES)	Is a database containing information about patients treated at NHS providers in England.
Hospital Standardised Mortality Review (HSMR)	Is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.
Information governance	Ensures necessary safeguards for, and appropriate use of, patient and personal information.
Mandatory training	The Organisation has an obligation to meet its statutory and mandatory requirements to comply with requirements of external bodies e.g., Health & Safety Executive (HSE), training is provided to ensure that staff are competent in statutory and mandatory
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
MSSA	Methicillin-sensitive *Staphylococcus aureus* (MSSA) is a bacteraemia caused by Staphylococcus aureus which is a serious infection associated with high morbidity and mortality and often results in metastatic infections such as infective endocarditis, which have a negative impact on patient outcomes.
National confidential enquiries (NCEPOD)	The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.
NHS Improvement	NHS Improvement is responsible for overseeing NHS foundation Trusts, NHS Trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
National inpatient survey	Collects feedback on the experiences patients who were admitted to an NHS hospital in 2019.
National institute for health and clinical excellence (NICE)	Is responsible for developing a series of national clinical guidelines to secure consistent, high quality, evidence-based care for patients using the National Health Service.

Abbreviations	Definitions
National institute of health research (NIHR)	Organisation supporting the NHS.
National patient safety agency (NPSA)	Lead and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
National reporting and learning system (NRLS)	Is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.
Never Events	Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS outcomes framework	Reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. To act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.
Open and Honest	North of England Trusts produces and publishes monthly reports on key areas of healthcare quality.
Palliative care	Focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.
Patient Reported Outcome Measures (PROMs)	Provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.
Payment by results (PBR)	Provide a transparent, rules-based system for paying Trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix.
Safety thermometer	Is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care?
Summary hospital-level indicator (SHMI)	reports mortality at Trust level across the NHS in England using standard and transparent methodology.
Urinary tract infection (UTI)	is an infection that affects part of the urinary tract

Annex 5: How to provide feedback.

We would like to hear your views on our Quality Account

The Quality Account gives the Trust the opportunity to tell you about the quality of services we deliver to our patients. We would like your views to help shape our report so that it contains information, which is meaningful to you and reflects, in part, the aspects of quality that matters most to you.

If you have any feedback regarding the Quality Account, please e-mail your comments to:
Warrington and Halton Teaching Hospitals, NHS Foundation Trust .qualityaccount@nhs.net

However, if you prefer pen and paper, your comments are welcome at the following address:

Write to:
Integrated Governance and Quality Team
Governance Office
Kendrick Wing
Warrington Hospital
Lovely Lane
Warrington, WA5 1QG

Annex 6: Other formats and Quality Accounts Availability

This document can also be made available in various languages and different formats including Braille, audio tape and large print.

Additional copies of the Quality Account can also be downloaded from the Trust website:
Warrington and Halton Hospitals NHS Trust - Annual Reports and Quality Accounts

Our website

The Trust's website gives more information about the Trust and the quality of our services. You can also sign up as a Trust member, read our magazine or view our latest news and performance information via: http://Warrington and Halton Teaching Hospitals, NHS Foundation Trust .nhs.uk

For more information, you can contact the Communications and Engagement Team:

Call: (01925) 662873

Email: Warrington and Halton Teaching Hospitals, NHS Foundation Trust .communications@nhs.net

Write to:
Communications and Engagement Team
Communications Office
Warrington Hospital
Lovely Lane
Warrington, WA5 1QG