Quality

We will..... **Always put our patients first** through high quality, safe care and an excellent patient experience

WHH QUALITY ACCOUNTS

2020-2021

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Quality Account

Quality is our number one priority.

Our Quality Account sets out how we have performed against the standards we set last year and what we will achieve in the coming year.

Part 1

1. A Statement on Quality from the Chief Executive, Simon Constable

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, we have embarked on an organisation- wide journey referred to as 'Moving to Outstanding'.

I am pleased to present our Quality Account for 2020/21. The Quality Account is an annual report which reviews our performance and progress against the quality of services that we provide and outlines our key quality priorities for the year ahead. It is an opportunity to celebrate our continued achievements and improvements that have impacted upon the care of our patients and their families.

In 2019 The Trust was awarded a 'good' CQC rating and has continued to build upon this, in our commitment to become an 'outstanding' organization delivering the highest standard of care for all our patients.

2020/ 2021 has been a challenging year for all healthcare settings as a result of the Covid -19 pandemic. Despite this every member of staff has contributed to the continued progress detailed within this Quality Account. We have continued to see and treat an increasing number of patients with more complex needs. This has stretched both services and staff. I am extremely proud of how all the staff at Warrington and Halton Teaching Hospital NHS Foundation Trust have proactively and efficiently managed the response to the Covid-19 pandemic and thank them for maintaining high standards of care for our patients and their families.

Looking ahead to 2021/22, we will continue to drive the Trust's Quality Strategy priorities. These are as follows:

Priority 1 The Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority.

Priority 2 Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes for our patients.

Priority 3 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.

The priorities have been chosen based upon national and local drivers and our internal governance intelligence, identifying areas for improvement. Emphasis remains upon working across organisational boundaries in partnership with others and across the Integrated Care System (ICS), to ensure that we

provide efficient and safe patient pathways to optimise health outcomes and enhance patient experience. We aim to become an integrated provider of clinically and financially sustainable, acute and community services providing outstanding care.

In conclusion, the Quality Account evidences that despite the challenges experienced throughout the year we have made significant progress in improving the care and services that we deliver to our patients. This will continue throughout the coming year and will be evidenced through our quality priorities and performance metrics for 2021/22.

I am pleased to present this year's Quality Account outlining the governance processes that have allowed myself and the Trust Board to authorise this document as a true and actual account of quality at Warrington and Halton Teaching Hospitals NHS Foundation Trust.

Signed by the Chief Executive to confirm that, to the best of his knowledge, the information in this document is accurate.

Simon Constable

Chief Executive

May 2021

1.1 Introduction from Kimberley Salmon-Jamieson, Chief Nurse and Deputy Chief Executive and Alex Crowe, Executive Medical Director

2020/21 marks the final year of our three yearly Quality Strategy which has been embedded across the Trust, forming an integral part of our Quality, People and Sustainability Framework (QPS). The Quality Strategy demonstrates our commitment to improving the quality of care for our patients and describes how we planned to make this a reality. We believe that supporting our staff and equipping them with the right, skills, training, is fundamental in achieving our vision to deliver the highest quality of patient care, every day.

It is important to recognise the challenges faced by all healthcare providers this year caused by the Covid-19 pandemic. We are incredibly proud of how our dedicated staff have responded to these challenges whilst continuing to keep themselves, our patients, and the community safe. We have continued to improve the services that we provide and have taken great strides forward in delivering many improvements to the safety and quality of patient care. Furthermore, we are committed to ensuring that we continually improve our services, to ensure that we are providing the best care that we can to our patients and their families.

In 2019 the Trust was awarded a 'Good' Care Quality Commission (CQC) rating and are on a dedicated journey to be recognised as a Trust that delivers an 'outstanding' level of care to all of our patients and their families. This will be achieved by ensuring that all staff who work in our hospitals continue to strive for excellence in all that they do evidencing the provision of safe, effective and responsive care.

In 2020/ 21 the Trust has expanded provision within the Quality Academy recognising the fundamental role of quality improvement and research in improving patient outcomes and quality of care. This has included the introduction of the Halton Clinical Research Unit (HCRU) and a newly appointed Head of Research.

Our Quality Strategy for 2021 - 2024 will now form the foundation for the next three years to further drive quality across the organisation on our journey to 'outstanding'. We will report measurable success in our Annual Quality Account and will commit to celebrating our achievements year on year.

Kimberley Salmon-Jamieson
Chief Nurse and Deputy Chief Executive
May 2021

Alex Crowe
Executive Medical Director
May 2021

Part 2

2. Priorities for Improvement and Statements of Assurance from Board

Warrington and Halton Teaching Hospitals NHS Foundation Trust provides services at Warrington Hospital, Halton General Hospital and the Cheshire and Merseyside Treatment Centre, located in the North West of England. The Trust has Operating income from patient care activities of £261 million, employs over 4,200 staff and provides nearly 500,000 appointments or treatments each year. The majority of our emergency care and complex surgical care is based at Warrington Hospital, whilst Halton General Hospital in Runcorn is a centre of excellence for routine surgery. The Halton campus is also home to our orthopaedic facility, The Captain Sir Tom Moore Building (formerly known as the Cheshire and Merseyside NHS Treatment Centre).

Our vision is laid out in Quality, People and Sustainability Framework (QPS); working to achieve nationally and locally set standards to ensure that patients receive the care they need when they need it. We also provide, like all NHS trusts, those services within a financial budget, which we are responsible for delivering. Some of the challenges we have set ourselves are:

- **Quality - Patient Experience** - By focussing 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.
- **People - Employee Wellbeing & Engagement** - Create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience.
- **Sustainability - Work with other acute care providers** to ensure that those services which need to be provided in an acute environment are the best that they can be and are clinically and financially sustainable.

2.1 Organisational Structure

The Trust’s organisational structure allows us to be more responsive to challenges through improved clinical engagement, strong and resilient leadership at all levels, with an emphasis on responsibility and accountability, to achieve the best for our patients and continuous improvement, transformation and innovation. The structure was developed collaboratively and facilitates clinical specialities to within a Clinical Business Unit (CBU) model. There are six Clinical Business Units within the Trust, who report into the Executive Directors. The Clinical Business Units are supported by ‘Clinical Support Services’ as well as ‘Corporate Support Services’.

The Trust’s organisational structure embraces the concept of true leadership synergy between the ‘triumvirates’ which brings together lead doctors, nurses/allied health professionals and managers working seamlessly with the wider corporate teams who are responsible for the clinical, operational and financial functioning of their CBU. The CBUs have been created through innovation and collaboration with partners with the aim of improving access and quality of care, whilst being cost efficient through effective ways of working.

2.2 Priorities for improvement - Improvement Priorities for 2020/21 update

The following improvement priorities and quality indicators were identified following a review of the domains of quality. Our commitment to achieving them was initially reported in the 2019/20 Quality Report. However, it was agreed that due to the challenges and impact of the COVID-19 pandemic the improvement priorities for 2019/20 were to continue until 31 March 2021.

The progress of each priority is reported on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee which reports into the Quality Assurance Committee. Where possible we include performance indicators to measure and benchmark our progress. This is reported on a monthly basis, via the Quality Dashboard to the Board of Directors.

The Trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The 3 quality priorities; Patient Safety, Clinical Effectiveness and Patient Experience are all supported by a separate group of indicators which are detailed below;

The following section includes a report on progress with our improvement priorities for 2020/21 which were:

Patient Safety Domain

- Gram Negative Bloodstream Infections - A 5% reduction in Gram Negative Bloodstream Infections (GNBSI)
- A 10% reduction in the overall number of inpatient Serious Harm Falls
- Deteriorating Patient - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions

Clinical Effectiveness Domain

- Implementation of the Medical Examiner role into the Trust
- Demonstrate that health care is based on the best available, current, valid and reliable evidence from GIRFT and NICE
- CBU Governance to be strengthened, to ensure that CBU Governance is embedded and consistently and effectively applied across all areas

Patient Experience Domain

- Implementation of the End of Life Serious Illness Programme
- Development and implementation of the Trust Learning Disability Strategy
- Reduce deconditioning and PJ Paralysis

Priority 1 – Patient Safety - We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.

- **Gram Negative Bloodstream Infections - A 5% reduction in Gram Negative Bloodstream Infections (GNBSI)**

Gram Negative Bloodstream Infections – Background:

The UKs 5-year national action plan (2019) details the ambition to halve healthcare associated Gram-negative bloodstream infections delivering a 25% reduction by 2021-2022 with the full 50% by 2023-2024.This priority links with our Quality Strategy to develop and enhance patient safety.

How progress will be monitored, measured and reported:
Infection Prevention and Control Sub Committee monthly.

Patient Safety and Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report is presented to the Quality Assurance Committee that will track milestones for the Quality Account priorities.

Gram Negative Bloodstream Infections - Implementation and Performance:

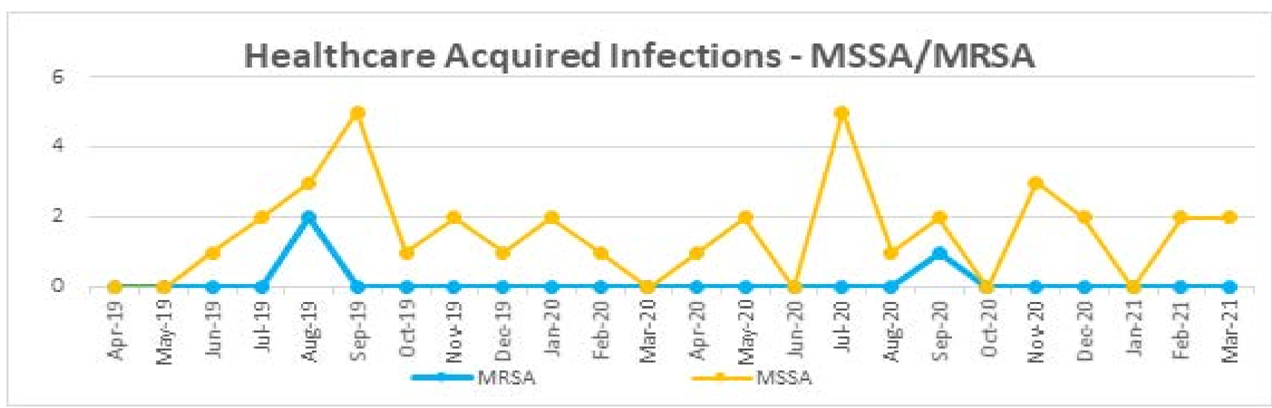
An overall summary of GNBSI and Healthcare Associated Infections is as follows:

- 1 MRSA Bacteraemia case (Methicillin-Resistant Staphylococcus aureus);
- 24 cases - MSSA (Methicillin-Sensitive Staphylococcus aureus) bacteraemia*;
- 45 cases - (15 unavoidable, 14 avoidable and 20 cases awaiting review by the CCG review panel to determine cause). Clostridium Difficile cases include community onset/healthcare associated and hospital onset cases;
- 45 cases - E. coli bacteraemia;
- 16 cases - Klebsiella bacteraemia*;
- 7 cases - P. aeruginosa bacteraemia*.

*There are no targets set nationally for MSSA; Klebsiella, P. aeruginosa bacteraemia cases.

The tables below are extracts from the Trust Integrated Performance Report.

Table 1 shows the results for MSSA bacteraemia and MRSA bacteraemia cases in 2020/21.

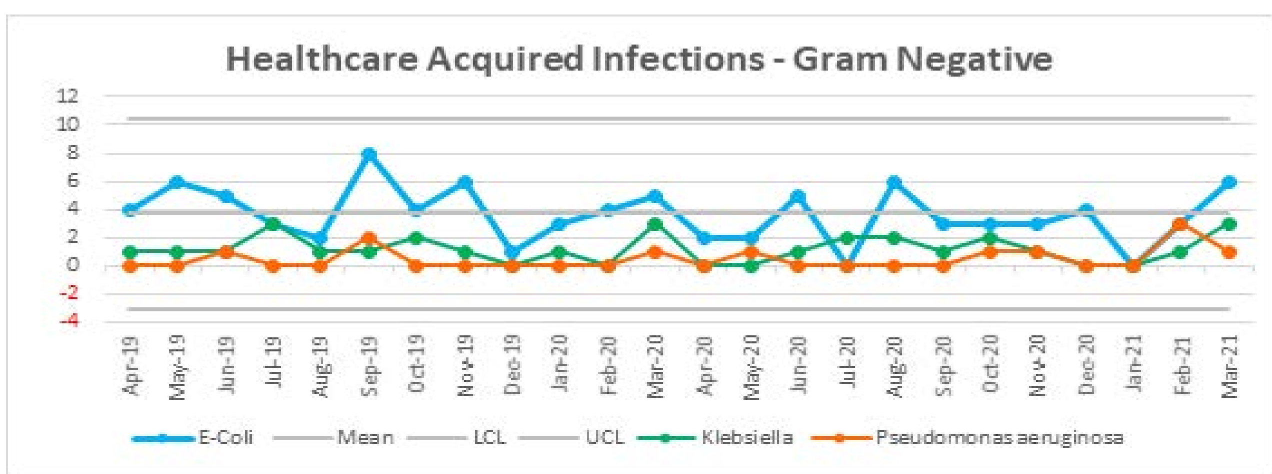


Investigations have been conducted into the MRSA bacteraemia case. This infection was considered avoidable

Table 2 shows the results for Clostridium Difficile (CDI) cases in 2020/21;

At the end of the year the Trust was over the locally agreed trajectory (44 cases) by 1 case. Meetings with the CCG are scheduled to review cases and agree avoidability status and this figure is subject to change.

Table 3 shows the results for Healthcare Associated infections in 2020/21.



E. Coli bacteraemia cases reduced by 5 cases compared to the previous financial year. The case apportionment rule changed from July 2020 to include community onset/ healthcare associated cases and these (11 cases) are included in the Trust case numbers. Improving performance in relation to Healthcare Acquired Infections remains a key priority for the Trust.

Improving performance in relation to Healthcare associated Infections remains a key priority for the Trust.

- **Serious Harm Falls - A 10% reduction in the overall number of Inpatient Serious Harm Falls**

Inpatient Serious Harm Falls – Background:

The human cost of falling in hospital can be devastating and may lead to pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also has an impact on quality of life.

This priority links in with our Quality Strategy as we are committed to achieve a 20% reduction in Serious Harm Falls by 2020/21.

How progress will be monitored, measured and reported:

Falls Steering group monthly.

Patient Safety and Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report is presented to the Quality Assurance Committee to track milestones for the Quality Account priorities.

Serious Harm Falls - Implementation and Performance:

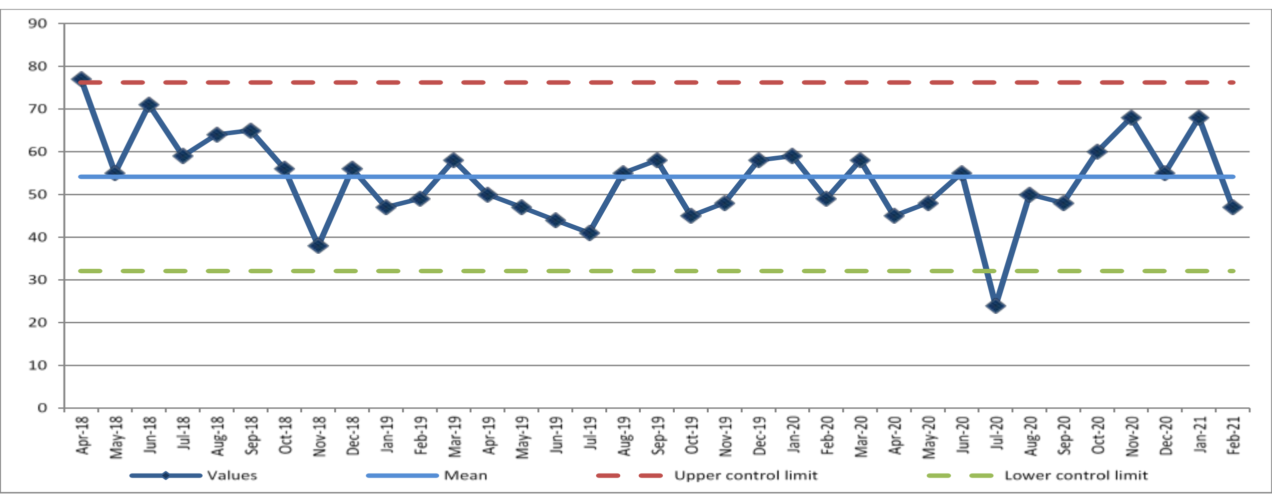
An overall summary of falls in 2020/21 is as follows:

Table 1 below is an extract from the Trust Integrated Performance Report and shows inpatient falls for 2020/21. The data indicates that from April 2020 there was a significant reduction in inpatient falls until September 2020, though this was expected due to the reduction in activity whilst providing care for patients with Covid-19. An increase in falls incidents was noted between October and December 2020 again reflective of clinical activity at this time. Incident reporting across the Trust remains within expected parameters.

Weekly falls meetings have continued to take place and key themes and learning shared. In addition, the safety brief includes a section around falls each day. The Quality Improvement (QI) arm of the academy was granted additional investment in 2020 and has now recommenced work around the falls collaborative. This is supported by the Deputy Director of Governance and Deputy Chief Nurse for Patient Safety. Performance is reported to the Patient Safety and Clinical Effectiveness Sub-Committee. Measures are in place to support continued work around the reduction in falls:

- Multifactorial documentation and collaborative expansion.
- Multifactorial audit pro-forma.
- Ward based Patient Safety Champions identified for all areas with clear role description completed.

Inpatient Falls – SPC Chart



- **Deteriorating Patient – Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions**

Deteriorating Patient – Background:

The increasing complexity of healthcare, an ageing population and shorter length of stay, means that hospital patients today need a higher level of care than ever before. Therefore, it is essential that hospital staff are equipped to recognise and manage deterioration (Department of Health 2019).

Improving performance in relation to the deteriorating patient remains a key priority for the Trust.

Deteriorating Patient - How progress will be monitored, measured and reported:

Patient Safety and Clinical Effectiveness Sub-committee monthly.

A quarterly Quality Report is presented to the Quality Assurance Committee to track milestones for the Quality Account priorities.

Deteriorating Patient - Implementation and Performance:

An overall summary of the deteriorating patient and the recording of NEWS2 score, escalation time and response time for unplanned critical care admissions in 2020/21 is as follows:

Weekly monitoring of NEWS2 compliance by Ward Managers and Matrons has continued for all areas.

- The Deteriorating Patient Group was established with NEWS2 compliance data presented within this forum. This is also reviewed at Patient Safety and Clinical Effectiveness Sub Committee.
- Due to the COVID19 pandemic, the eObs roll out was delayed. Implementation has now commenced.

Priority 2 – Clinical Effectiveness - We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time

- **Implementation of the Medical Examiner Role into the Trust**

Implementation of the Medical Examiner Role into the Trust - Background:

There is a national requirement to have a Medical Examiner(s) (ME) in Acute Trusts. Medical Examiners are part of a national network of specially trained independent senior doctors from any specialty. They are overseen by the National Medical Examiner, they scrutinise all deaths that do not fall under the coroner's jurisdiction and to agree the proposed cause of death and the overall accuracy of the medical certificate cause of death. Embedding the Medical Examiner role, ensure effective decisions about health care are based on the best available, current, valid reliable evidence.

Implementation of the Medical Examiner Role into the Trust - How progress will be monitored, measured and reported:

Mortality Review Steering Group held monthly.

Mortality and Morbidity (M&M) meetings monthly

Patient Safety and Clinical Effectiveness Sub-committee held monthly.

A quarterly Quality Report presented to the Quality Assurance Committee will track milestones for the Quality Account priorities.

A quarterly report is provided to the National Medical Examiner Office via the online portal.

Sharing of this data with the Quality Assurance Committee and other relevant groups in the Trust.

A report of the same data is provided to the Head of Clinical Effectiveness and Quality and the Clinical Effectiveness Manager on a monthly basis.

Any identified learning is shared with the Mortality Review Group, Mortality and Morbidity meetings and the Governance team via Datix on a case-by-case basis if applicable.

Quarterly update meeting with the trusts Clinical Effectiveness Manager.

Implementation of the Medical Examiner Role into the Trust – Implementation and Performance:

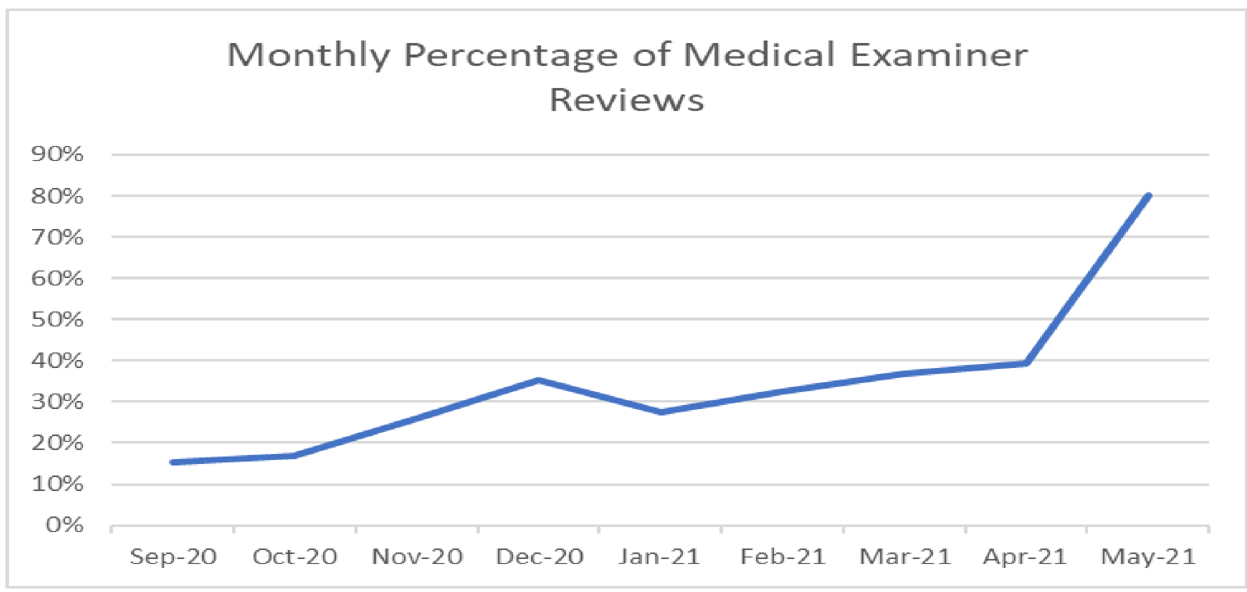
The Chief Medical Examiner, Medical Examiner and Medical Examiner Officer have been appointed. The Medical Examiner Office is successfully overseeing bereavement services, ensuring thorough scrutiny of all non-coronial deaths and offer a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one. The Medical Examiner service has successfully started to review deaths and is reviewing around 50-60% of all deaths with an aim to review 100% by end of May 2021.

The Medical Examiner service has been approached and has agreed to act as a pilot site for community implementation in May 2021. This will enhance learning with additional support for families across the wider community.

There has been a reduction in the number of referrals made to the Coroner since the implementation of the Medical Examiners Services. 48 referrals were made to the Coroner’s Office in the first 3 months of 2020, when comparing to the same date range 2021, there is a reduction of 18 referrals made. This is a positive reduction and negates the need to request clinical statements for further clarification whilst improving the experience for bereaved families.

Table 1 below details the number of deaths scrutinised by the Medical Examiner(s) in 2020/21 from when the service was implemented in September 2020.

Date	Total Death	Cases Reviewed	Monthly Percentage	MCCD Delay > 3Days	Registrar Rejected MCCDs	Coroner Referrals	SJR Referrals	M&M Referrals	Learning Potential
Sep-20	85	13	15%	0	0	0	0	0	1
Oct-20	125	21	17%	0	0	0	2	1	1
Nov-20	124	32	26%	2	0	4	0	2	5
Dec-20	116	41	35%	9	0	1	3	3	1
Jan-21	160	44	28%	2	0	1	0	3	4
Feb-21	120	39	33%	1	0	2	2	3	4
Mar-21	95	35	37%	0	0	0	0	1	2
Apr-21	79	31	39%	1	0	2	0	0	1



- **Demonstrate that health care is based on the best available, current, valid and reliable evidence from GIRFT and NICE**

Demonstrate that health care is based on the best available evidence from GIRFT and NICE - Background:

The Getting it Right First Time (GIRFT) programme is a national programme designed to improve the quality of care within the NHS by reducing unnecessary variations in service. By sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

NICE develops national guidance, advice and standards on promoting good health, preventing and treating ill health and on the care, people should receive from social care. NICE guidance covers a range of areas including health technologies, clinical practice, public health and social care. NICE guidance aims to improve quality by providing health and social care professionals, and patients and the public, with the information they need to make decisions about treatment and care.

GIRFT and NICE - How progress will be monitored, measured and reported:

Patient Safety & Clinical Effectiveness Sub-committee

A quarterly Quality Report is presented to the Quality Assurance Committee that will track milestones for the Quality Account priorities.

Demonstrate that health care is based on the best available evidence from GIRFT, Right Care and Model Hospital - Implementation and Performance:

The COVID-19 pandemic has impacted upon the GIRFT Regional Implementation Teams due to redeployment and subsequent redesign, which is outside of any Trust's control. As a result of these operational challenges most GIRFT activity by the regional teams was paused. During this time the national GIRFT programme continued to analyse data and provide GIRFT national speciality reports. The national reports have provided a useful benchmark until the programme recommences.

In August 2020 GIRFT stated its intention to recommence the GIRFT programme utilising virtual platforms. In addition, GIRFT have provided webinars and workshops to share best practice and promote continued improvement and provided GIRFT post Covid recovery guidance and recommendations for different speciality and organisational areas.

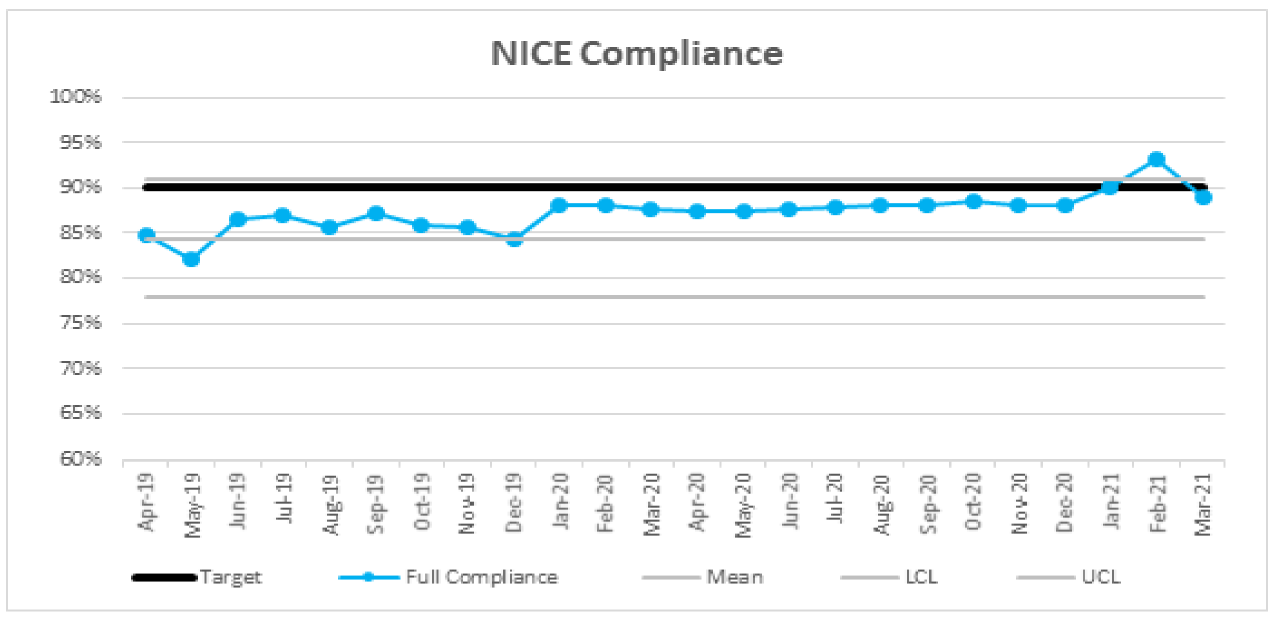
GIRFT's model of analysing data to uncover best practice supports the identification of ideal service pathways and provides case studies for trusts to adapt to their own needs. GIRFT has continued to help specialties refocus within the constraints of COVID.

In October 2020, the Trust was notified that the majority of the GIRFT team had been redeployed during the pandemic and since September 2020 there has been a reconfiguration within GIRFT; meaning the implementation managers are now aligned to STP/ICS geographies rather than specialty focused. There are two implementation managers for Cheshire and Merseyside.

GIRFT had planned to roll out a web platform to provide accessibility to view and update actions for specialities and condition specific GIRFT areas, for example VTE. This was delayed during Covid-19 with plans for implementation in 2021/22.

Demonstrate that health care is based on the best available evidence from NICE - Implementation and Performance:

NICE guidance is applied to support the improvement of clinical outcomes using evidence-based practice. The graph below details the Trust compliance against the 90% required target. The graph below demonstrates a positive increase in overall compliance for NICE over the last 12 months.



A baseline toolkit has been created to support staff with the completion of baseline assessments.

- **CBU Governance will be further strengthened and embedded consistently and effectively across all areas:**

CBU Governance to be strengthened - Background:
CBU Governance will be further strengthened ensuring consistency across the organisation to ensure that there is no unnecessary variation in the quality of care provided. It will also emphasis learning as part of the Trust learning framework to optimise opportunity to continually improve clinical practice Trustwide.

How progress will be monitored, measured and reported:
Patient Safety & Clinical Effectiveness Sub-committee

CBU Governance to be strengthened ensuring consistency across the organisation. Clinical governance aims to shift the performance of all health organisations closer to the standards of the best. It hopes to reduce unjustifiable variations in quality of care provided.

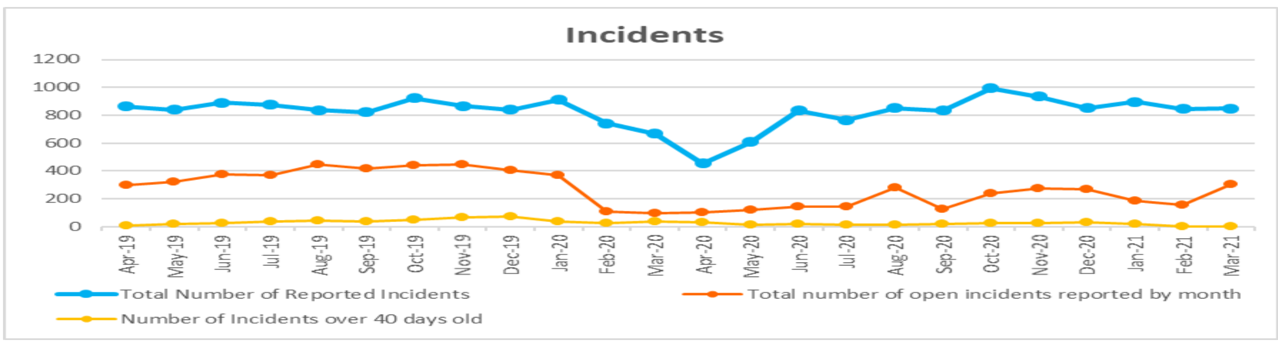
A quarterly Quality Report is presented to the Quality Assurance Committee that will track milestones for the Quality Account priorities.

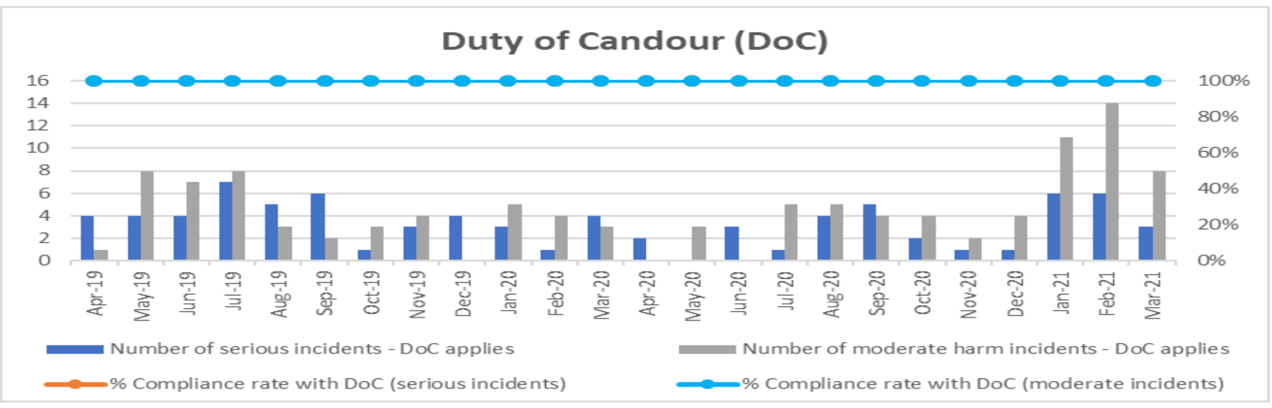
CBU Governance to be strengthened - Implementation and Performance:

MIAA audit has been completed and key recommendations are detailed within a robust action plan.

Complaints have reported an increase in responses provided within timeframe, with no breaches noted. During the pandemic there was a temporary national pause on complaints. During this period the Trust continued to respond to all high-risk complaints and all patients with an existing complaint were contacted. Complainants continue to be offered meetings using alternative modalities such as Microsoft Teams if this is their preferred method of communication. Updates on the complaints position are provided to the Patient Safety and Clinical Effectiveness Sub Committee, Quality Committee and Trust Board. There is also a monthly Complaints Quality Assurance Group led by the Trust Chairman.

Incident investigations have continued to be undertaken as normal with SMART action plans in place. All investigations moderate or above are presented by the Investigating Officer at the Weekly Meeting of Harm chaired by the Chief Nurse, Deputy Chief Executive providing assurance of additional scrutiny.
Incident reporting levels are regularly monitored and there are no incidents over 40 days. The Trust remain fully compliant with all Duty of Candour requirements.





Priority 3 – Patient Experience - *We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for*

- **Implementation of the End of Life Serious Illness Programme**

Implementation of the End of Life Serious Illness Programme - Background:

WHH has made a formal commitment to creating opportunities for the implementation of the End of Life Serious Illness programme. The National End of Life Care Programme aims to:

- Bring a step change in the quality of care for people approaching the end of life.
- To enhance choice at the end of life.
- To reduce inequalities (e.g. Geographical and cancer vs. Non-cancer).
- To prepare for the demographic challenge: increasing numbers of deaths, particularly amongst people over 85 years.
- To raise the profile of end of life care.

Implementation of the End of Life Serious Illness Programme - How progress will be monitored, measured and reported:

End of Life Care Steering Group Monthly

A quarterly Quality Report to the Quality Assurance Committee will track milestones for the Quality Account priorities

Implementation of the End of Life Serious Illness Programme - Implementation and Performance:

The Serious Illness Care Programme is a system level intervention designed to improve the lives of people with a serious illness by optimising the timing, frequency and quality of serious illness conversations. Comprising clinical tools, training support and systems innovations the Programme empowers patients to actively participate in thinking and planning for the future with their illness.

WHHFT is leading and supporting the implementation of the programme at four Trusts across the UK:

- ✓ Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHHFT)
- ✓ North West *London* University *Healthcare NHS Trust (NWL***)**
- ✓ Liverpool University Hospitals NHS Foundation Trust (LUH)
- ✓ North East Academy Partnership (encompasses Gateshead Newcastle and Northumbria.) The Partnership joined in November 2020

WHHFT is currently in the Implementation Phase. Cardiology and Gastroenterology are the two pilot sites. Gastroenterology will focus upon patients with advanced liver disease and Cardiology will focus upon patients with advanced cardiac failure. Clinical Leads have been identified and both specialties are now exploring workflow, screening and patient identification. Gastroenterology have commenced a focused baseline evaluation with support from trainees.

Work has been focused on systems change and customising workflow. The training programme has been developed to facilitate virtual delivery including the experiential skills section.

Programme implementation will be underpinned by research using a mixed methods approach. Data will be collected over a 12-month implementation period, to illustrate the impact of the conversation on the care provided to patients. This data will enhance the UK evidence base and provide important information to support future roll out. Integrated Research Application System and Health Research Authority approval has now been secured.

The Royal College of Physicians are keen to support dissemination of the Programme and joint educational initiatives are planned for 2021 including delivery via the Royal College of Physician Player and a joint national Foundation workshop.

The Serious Illness care programme produces a quarterly Progress Report for all sites with full details of progress for the four sites benchmarked against the Programme Roadmap. The most recent Progress Report was published in December 2020.

- **Development and Implementation of the Trust Learning Disability Strategy**

Development and Implementation of the Trust Learning Disability (LD) Strategy- Background:

The LD Strategy aspires to improve life choices and quality of life of people with LD by ensuring that they are included in every aspect of community life as equal partners and that the voice of every person with LD is heard and respected.

Patients with LD are alerted to the Safeguarding Adults team daily via the WHH electronic flagging system and to the CBU leads. The Lead Nurse for Adult Safeguarding is the identified WHH LD lead. Every patient receives a welfare check, the frequency of the contact is determined by the individual need of the patient.

The welfare check includes:

- Guidance to the ward team about the use of the passport.
- Guidance to the ward team about reasonable adjustments.
- Guidance to the ward team about the Mental Capacity ACT and DoLS and Best Interest Decisions including DNACPR.
- Discharge planning.
- Assist with contact to the community teams.
- All contact is documented in the electronic patient record.

The Trust LD lead attends:

- Monthly LeDeR multi-agency review panel.
- Quarterly Warrington LD Board
- Quarterly regional LD forum
- Quarterly regional transition forum
- Newly formed LD/Autism steering group

- Launch of the LD/Autism steering group has taken place with trust wide attendance

Level 1 and 2 LD/Autism training is undertaken 6 times per week and is delivered by the LD/Autism practice development nurse trainer.

As part of this quality priority the following work has been undertaken with additional plans in place to optimise patient care for this client group in 2021 /22.

- Work with partner agencies and third sector underway to enhance how we care for our patients by strengthening partnership working.
- ED&I collaborative working at WHH to improve care and access to WHH for patients and families, a new Friends and Family easy presentation is under construction.
- Transition support for people entering adult services via work developed between Alder Hey and the Safeguarding team.
- Support for patients requiring intense reasonable adjustment to access care and treatment, ensuring that planning takes place with families, carers and Multi-disciplinary teams to enable appropriate admission.
- Specific work streams have targeted education about reasonable adjustments enabling staff to continually improve the standard of care delivered.
- There have been several improvements in how we support our patients with Learning Disabilities, these are detailed below.
- There is a Trustwide LD/ Autism improvement action plan.
- WHH has a policy that supports staff practice regarding the care of patients with Learning Disabilities.
- WHH has an Acute Care Admission Pathway to support the care of patients with LD and or autism, enabling staff to consider reasonable adjustments.
- There is an identified area in Accident and Emergency (A/E) to support the sensory needs of patients.

Reduce deconditioning and PJ Paralysis

Reduce deconditioning and PJ Paralysis - Background:

The PJ Paralysis Challenge is a national campaign aimed at helping people to not spend any longer in hospital than is clinically necessary. Focusing on the importance of patients' time, healthcare professionals across the NHS and social care have been swapping their uniforms for pyjamas to encourage patients to take positive measures to boost their recovery.

How progress will be monitored, measured and reported:

Patient Safety and Clinical Effectiveness Sub-committee held monthly.

A quarterly Quality Report presented to the Quality Assurance Committee will track milestones for the Quality Account priorities.

Reduce deconditioning and PJ Paralysis - Implementation and Performance:

During the COVID 19 Pandemic, the implementation plan was paused. This now forms part of the falls Quality Improvement collaborative.

2.3 Improvement Priorities and Quality Indicators for 2021/22 - How we identify our priorities – stakeholder engagement

The Trust has a duty to fully engage with stakeholders and members to ensure that we are listening to their views on quality and quality priorities moving forward. The priorities have been identified through receiving feedback and regular engagement with governors, staff, patients, the public, and commissioners of NHS services, overseeing scrutiny groups and other stakeholders. Progress on the planned improvements are reported through the Trust's Quality Assurance Committee and ultimately through to Trust Board.

Our staff, governors, members and patients are the eyes and ears of the organisation and their views are constantly sought to ensure that we are focussing on the things that will make the most difference. We surveyed staff, patients and visitors, through the Staff Survey and the Friends and Family Test and from those results we capture the views of the staff and wider public in relation to the range of priorities.

2.4 Improvement Priorities for 2021/22

The Trust Board, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2021/22 will continue to be:

We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.

We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time.

We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for.

In order to embed the above improvement priorities, we have established nine local quality indictors to support their implementation.

Full details of the Patient Safety, Clinical Effectiveness and Patient Experience indictors can be seen in the sections below.

2.5 Local Quality Indicators 2021/22

The Trust Board, in partnership with staff and Governors, has reviewed performance data relating to quality of care and have agreed that in addition to our improvement priorities our quality indicators for 2021/22 will include:

Patient Safety Domain

- DNACPR- Improve communication with family/patients with effective communication, documented discussion and inclusive decision making.
- COVID Recovery- robust waiting list management, with clear clinical oversight to avoid and recognise potential patient harm.
- A reduction in Gram Negative Bloodstream Infections (GNBSI) – ensuring that there is a 5% reduction in Bloodstreams infection.

Clinical Effectiveness Domain

- Medical Examiner- embed the service across the acute setting and act as the pilot site for community implementation.
- Evidence-based Interventions**-** Ensure effective decisions about health care are based on the best available, current, valid and reliable evidence.
- CBU Governance- to be strengthened ensuring consistency across the organisation.

Patient Experience Domain

- End of Life – Serious Illness Programme; Better Communication and Better Care for those sadly reaching the end of life.
- Learning Disabilities and Mental Health Strategies – Trustwide implementation of the Trust Learning Disability Strategy.
- Improve patient experience by enhancing the standard and timely delivery of nutrition.

OUR 2021–22 QUALITY PRIORITIES

The improvement aims	The quality priorities	The outcome
IMPROVE PATIENT SAFETY	1. DNACPR - improving communication with patients and families 2. COVID-19 recovery - robust waiting list management with senior clinical oversight 3. Gram-negative bloodstream infections - achieving a 5% reduction	A safety and learning culture where quality and safety are everyone's priority
IMPROVE CLINICAL EFFECTIVENESS	4.Medical Examiner - embedding the service and piloting community roll out 5.Evidence based interventions - effective decisions based on the best evidence 6.CBU governance - strengthened and consistent across the organisation	Doing the right things, the right way, to achieve the right outcomes for our patients
IMPROVE PATIENT EXPERIENCE	7.End of life Serious Illness Programme - improving care and communication 8.Learning disabilities and mental health - implementing and embedding our strategy 9.Nutrition - To ensure that patients have access to a choice of food and nutrition.	Patient experience at the heart of all we do, seeing the person in the patient

2.6 Statements of Assurance from the Board

During 2020/21, the Warrington and Halton Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted seven 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 all of these relevant health services.

The income generated by the NHS services reviewed in 2020/21 represents 100 per cent of the total income generated from the provision of relevant health services by the Warrington and Halton Teaching Hospitals NHS Foundation Trust for 2020/21.

2.7 Data Quality

The data is reviewed by the Board of Directors in the form of a Quality Dashboard. The data reviewed covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Our success in achieving the improvement priorities will be measured, where possible, by using nationally benchmarked information from the NHS Information Centre; Healthcare Evaluation Data (HED system); Advancing Quality Alliance (AQuA); NHS England datasets including the Safety Thermometer; Friends and Family, Dementia and VTE Risk Assessments and national survey results. WHH also uses measurement tools that are clinically recognised for example the Pressure Ulcer Classification Tool of the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP).

The processes that we use to monitor and record our progress has been audited by Mersey Internal Audit Agency to provide assurance on the accuracy of the data collection methods employed.

2.8 Participation in National Clinical Audits and National Confidential Enquiries 2020/21

During 2020/21 Warrington and Halton Teaching Hospitals NHS Foundation Trust participated in **29** National Clinical Audit Projects. The National Clinical Audits Warrington and Halton Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2020/21 were as follows:

HQIP ID	National Clinical Audit Project
2.	BAUS Urology Audit – Nephrectomy British Association of Urological Surgeons (BAUS)*
4.	Case Mix Programme (CMP) Intensive Care National Audit and Research Centre (ICNARC)
8.	Emergency Medicine QIPs *
9.	Falls and Fragility Fractures Audit programme (FFFAP) Royal College of Physicians (RCP) *
10.	Inflammatory Bowel Disease (IBD) Audit 3
13.	Maternal, new-born and Infant Clinical Outcome Review Mothers and Babies: Reducing Risk through Audits and Programme Confidential Enquiries across the UK (MBRRACE-UK)
16.	National Asthma and Chronic Obstructive Pulmonary Royal College of Physicians (RCP) Disease (COPD) Audit Programme (NACAP) *
17.	National Audit of Breast Cancer in Older People (NABCOP) Royal College of Surgeons (RCS)
18.	National Audit of Cardiac Rehabilitation (NACR) University of York
19.	National Audit of Care at the End of Life (NACEL) NHS Benchmarking Network
22.	National Audit of Seizures and Epilepsies in Children and Royal College of Paediatrics and Child Health (RCPCH) Young People (Epilepsy12)

HQIP ID	National Clinical Audit Project
24.	National Cardiac Arrest Audit (NCAA) Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK
25.	National Cardiac Audit Programme (NCAP) Barts Health NHS Trust *
28.	National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia 3
29.	National Diabetes Audit – Adults NHS Digital *
30.	National Early Inflammatory Arthritis Audit (NEIAA) British Society for Rheumatology (BSR)
31.	National Emergency Laparotomy Audit (NELA) Royal College of Anaesthetists (RCOA)
32.	National Gastro-intestinal Cancer Programme 1, 2, 3
33.	National Joint Registry (NJR) Healthcare Quality Improvement Partnership (HQIP) *
34.	National Lung Cancer Audit (NLCA) Royal College of Physicians (RCP)
35.	National Maternity and Perinatal Audit (NMPA) Royal College of Obstetricians and Gynaecologists (RCOG)
36.	National Neonatal Audit Programme - Neonatal Intensive Royal College of Paediatrics and Child Health (RCPCH) and Special Care (NNAP)
37.	National Ophthalmology Audit (NOD) Royal College of Ophthalmologists (RCOphth)
38.	National Paediatric Diabetes Audit (NPDA) Royal College of Paediatrics and Child Health (RCPCH)
39.	National Prostate Cancer Audit (NPCA) 1, 2
40.	National Vascular Registry 1,
47.	Sentinel Stroke National Audit programme (SSNAP) King's College London
48.	Serious Hazards of Transfusion: UK National Serious Hazards of Transfusion (SHOT) Haemovigilance Scheme
51.	Major Trauma Audit Trauma Audit Research Network (TARN)

*Denotes projects with multiple work streams

The following table presents the National Clinical Audits that Warrington and Halton Teaching Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2020/21. The below details the compliance rate of cases submitted in 2020/21. Those that indicate a lower level of compliance have been impacted by the Covid-19 pandemic with plans in place to optimise compliance.

HQIP ID	National Clinical Audit	Participated	Data collected	Number / % of cases submitted 2020/2021
2	BAUS Urology Audit	Yes	Yes	50% (5)
4	Case Mix Programme (CMP ICU)	Yes	Yes	100%
8	Emergency Medicine QIPs: Fractured Neck of Femur	Yes	Yes	100% (53)
8	Emergency Medicine QIPs: Pain in Children	Yes	Yes	100% (30)
8	Emergency Medicine QIPs: Homeless Inclusion health	NA	NA	Postponed
9	Falls and Fragility Fractures Audit Programme (FFAP): National Audit of Inpatient Falls	Yes	Yes	Ongoing - 14 cases submitted
9	Falls and Fragility Fractures Audit Programme (FFAP): National Hip	Yes	Yes	100% (315)

HQIP ID	National Clinical Audit	Participated	Data collected	Number / % of cases submitted 2020/2021
	Fracture Database			
10	Inflammatory Bowel Disease (IBD) Biological Therapies Audit	No	No	WHTH did not participate
13	Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes	100%
16	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Pulmonary rehabilitation- organisational and clinical audit	NA	NA	PR Services suspended from March 2020 to Oct 2020 – Submission period not inputted due to suspension
16	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Adult Asthma	NA	NA	Audit participation was not mandatory during pandemic. Reporting period has re-opened and is now ongoing.
16	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	NA	NA	Audit participation was not mandatory during pandemic. Reporting period has re-opened and is now ongoing.
16	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Paediatric Asthma	Yes	Yes	Ongoing data collection – 29 pts inputted so far next deadline is May 2021
17	National Audit of Breast cancer in Older People (NABCOP)	Yes	Yes	60%
18	National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	Ongoing data collection
19	National Audit of Care at the End of Life (NACEL)	NA	NA	Round 3 postponed due to COVID
20	National Audit of Dementia (NAD)	NA	NA	Suspended
22	National Audit of Seizures and Epilepsies in Children and Royal College of Paediatrics & Child Health (RCPCH) Young People (Epilepsy12)	Yes	Yes	Data Collection ongoing for Cohort 3 – extension due to Covid.
24	National Cardiac Arrest Audit (NCAA)	No	No	WHTH formally withdrawn from the National Cardiac Arrest Audit
25	National Cardiac Audit Programme (NCAP): Myocardial Ischaemia	Yes	Yes	Ongoing data collection 441 submitted
25	National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	Yes	Yes	Ongoing data collection 336 submitted
28	National Comparative Audit of Blood Transfusion Programme	NA	NA	Postponed
29	National Diabetes Audit – Core	Yes	Yes	Ongoing data collection – Next Submission date May 2021
29	National Diabetes Audit - National Diabetes Foot Care Audit	Yes	Yes	Continuous data collection- 29 patients submitted for this time period
29	National Diabetes Audit - National	Yes	Yes	100%

HQIP ID	National Clinical Audit	Participated	Data collected	Number / % of cases submitted 2020/2021
	Diabetes Inpatient Audit (NaDIA) -			
29	National Diabetes Audit - National Pregnancy in Diabetes Audit	Yes	Yes	100% (11)
30	National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Ongoing data Collection
31	National Audit of Emergency Laparotomy (NELA)	Yes	Yes	Ongoing data Collection
32	National Oesophago-gastric Cancer Audit (NOGCA)	Yes	Yes	<65% - our case ascertainment figure is being reviewed by NHS Digital.
33	National Joint Registry (NJR)	No	No	Due to Covid-19
34	National Lung Cancer Audit (NLCA)	Yes	Yes	100%
35	National Maternity & Perinatal Audit (NMPA)	Yes	Yes	Ongoing data collection – extended to July 2021
36	National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
37	National Ophthalmology Database Audit (NOD)	Yes	Yes	Data extraction is in progress for this period.
38	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Data Collection ongoing
39	National Prostate Cancer Audit (NPCA)	Yes	Yes	100%
47	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	April-June 2020 80-89% July to March 90%+
48	Serious Hazards of Transfusion (SHOTS)	Yes	Yes	100% (12)
51	Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing data collection - 91 cases submitted

**Due to the ongoing pandemic the compliance rate is not as expected due to clinicians not undertaking non urgent activity.*

National Confidential Enquiries

During 2020/21 there were 4 NCEPOD studies, of which WHH were eligible to participate in the following 3:

ID	National Confidential Enquiries
1	Out of Hospital Cardiac Arrest (OHCA)
2	Dysphagia in Parkinson's Disease
3	Acute Bowel Obstruction

2.8.1 National Clinical Audit

The reports of 14 National Clinical Audits were reviewed in 2020/2021 and Warrington and Halton Teaching Hospitals NHS Foundation Trust is taking the following actions to improve the quality of healthcare provided:

National Audit Title	Quality Improvement Action Plan
National Audit of Breast Cancer in Older Patients (NABCOP)	Amend MDT proforma to include WHO performance status
National Audit of End of Life Care (NACEL)	Essential/Bespoke training programme to include • Recognising imminent death • Involvement in decision making • Needs of families & others • Individual care plan
National Audit of Dementia (NAD)	Introduction of standardised 4AT screening tool into adult ED
	Introduction of Abbey pain scale into the adult Emergency Department
	Introduction of dementia information leaflet for patient, family or carers on admission to hospital
	Delirium and its relationship to dementia will be included in the dementia awareness face to face session
	Include on the patient menu card the option to order finger foods in replacement of a standard meal
	Inclusion of a 4AT heading within the discharge documentation the occurrence of delirium and/or behavioural symptoms of dementia and recommendations for ongoing assessment or referral to a memory clinic/community team post discharge
	Reporting of inappropriate moves, falls and readmission within 30 days for all dementia patients to the Trust Board
National Sentinel Stroke National Audit Programme (SSNAP)	To investigate the reduction of audit compliance scoring on the SSNAP and ascertain which aspects are causing the impact
	To submit a business case for increased staffing levels of speech and language therapy for stroke
	To increase the intensity of physiotherapy and occupational therapy within existing resources
Bronchiectasis Audit (British Thoracic Society)	CT update checklist by Physiotherapist
National Pregnancy in Diabetes Audit (NPID)	Promote fact that Warrington women can now self-refer without waiting for GP referral using
	Local GPs being encouraged to refer all patients with diabetes and pre-diabetes to structured education programmes which includes information on pre-conception care/targets
	Pre-conception requirements and available pre-conception clinics promoted at local community diabetes sessions
	Promote pre-conception care to potentially fertile patients in WHH service
National Lung cancer Audit (NLCA)	Confirmation of data accuracy regarding pathological confirmation rate
	Confirmation of data discrepancy between actual and adjusted mean for 'Surgery in NSCLC' metric
	Improvement in SACT for NSCLC and SCLC rates by improving MDT working and liaison with Clatterbridge Centre for Oncology (CCO)
	Improvement in Lung CNS metric and ongoing support of lung cancer pathway/ FDS by expansion of Lung CNS hours and confirmed investment in Early Diagnosis Support Worker (EDSW) role
National Asthma and Chronic Obstructive Pulmonary Disease Audit	Review impact of 7 day working on number of patients seen and length of stay

National Audit Title	Quality Improvement Action Plan
Programme (NACAP)	Review spirometry and obtaining results
	Liaise with lifestyle team re better prescription of and access to nicotine replacement therapy
National Hip Fracture Database (NHFD)	Orthogeriatric Consultant post (0.5WTE) to be advertised
	Trauma and Orthopaedic Nurse post to be advertised
	Funding to be identified for the trauma team
	KPIs to be split into categories for visibility on what is consistently being achieved and what is consistently underperforming
	Task and finish groups to be set up with the support of QI Team
National Prostate Cancer Audit (NPCA)	Optimal Pathway- this is being planned through Alliance Network
National Ophthalmology Database (NOD)	Encourage all consultants to input the data of the surgical procedure, the Risk score and the complications in Medisoft / Medisight
	Possibility of standardising the Data between ORMIS and MEDISOFT with the help of IT, to create a more efficient report
National Paediatric Diabetes Audit (NPDA)	Increase uptake of Insulin pumps and continuous glucose monitor (CGM)
	Eye Screening results to follow-up from eye screening team
	Improve recording of blood pressure (BP) and foot examination in annual checks
National Maternity and Perinatal Audit (NMPA)	Continue implementation of Saving Babies Lives 2
	Continue to benchmark against other providers
	Complete a local audit
National Emergency Laparotomy Audit (NELA)	Engage with intensive care team to improve preoperative involvement of intensivist in perioperative management of emergency laparotomy patients including appropriate post- operative admission to critical care
	Elderly medicine specialist reviews in patients > 70 years

2.8.2 Local Clinical Audit

The reports of 80 local clinical audits were reviewed in 2020/21 and Warrington and Halton Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
The Chest X-ray – an Image Quality Audit	• New aspect markers to be added to each XR room to encourage radiographers to use them. • Education around chest imagining technique, to help give radiographers a refresher, or to boost their confidence with adapted technique.
Re-audit of compliance with the British Society for Haematology (BSH) guideline for the use of imaging in the management of patients with myeloma	• No Quality Improvement Action Plan – High Assurance
Re-audit on use of Laboratory investigations recommended by NICE guidance 35 on Myeloma	• To continue to follow the laboratory guidance from NICE CG35 on myeloma
Major Haemorrhage Protocol activations during 2019	• Include MHP activation process in the doctors training for 2020.
Re-audit: Review of timing of CT	• Discuss with staff in handling requests from clinician to the

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
guided biopsies	vetting radiologist and interventional nurse to reduce number of days to complete stage 1. • Discuss within the department regarding possibility of increasing the capacity / slots in performing CT guided biopsy. • Re-audit after 2-year time.
Therapies Compliance with Baseline Assessment Tool for NICE Guidelines on Falls.	• Provide education and training on best practice care for patients who fall via In Service Training. • Conduct a review of services and disseminate information to inpatient therapy teams via team leaders / clinical leads.
Following shoulder X-ray in MSKCATS, how many patients require intervention, as first line of action, other than physiotherapy or Self- management?	• Discussion with Upper Limb ESP/Orthopaedic Consultants Upper limb at WHH, re up-to-date practice re Patients with shoulder pain. • Review of MSKCATS Primary Care pathways for Shoulder patients. • Liaise with other Primary Care MSKCATS services to determine their guidelines • Make any changes to clinical practice/pathways as appropriate • Re- Audit against changes implemented
Management of Short-term Recall in Breast Screening	• Repeat Audit in 2 years
Thyroid cancer histopathology reports	• Thyroid cancer MDS to be included in thyroid cancer histopathology report • Re audit
An Audit on Infection Complications Post Prostate TRUS Biopsy at WHHFT	• Repeat audit in six months' time (as prophylactic antibiotic choice has been changed recently) • Send the audit findings to Urology teams
Audit on histological reporting of colorectal cancer	• Circulate the new MDS. • Remind pathologists to measure CRM and record tumour deposits in all cases. • Remind pathologists to select the best tumour block with percentage of tumour. •
Compliance with the British Society for Haematology new guideline for the diagnosis and management of polycythaemia vera	• EPO levels should be requested for every patient. Needs collaboration with the Haem lab in order to minimize the risk of no processing samples • Better documentation of arterial O2 saturation in the clinic letters
Radiography of NG Tube Positioning	• Email the audit presentation and recommendations to the trust clinical governance/ audit department / lead radiographer / medical directorate for patient safety. • Re-audit as per plan
To improve the efficiency and timeliness of care received by patients attending A&E physiotherapy clinics at WHH.	• A new Lorenzo notes template to be introduced to be used while documenting notes on Lorenzo. • To outline notes standard to be followed while documenting A&E physiotherapy notes. • To carry out acute knee assessment training for staff. • Presentation of this audit at the Trauma meeting to request ordering investigations right for all A&E physiotherapy staff.

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
	• To carry out acute knee assessment training for staff. • To carry out training for A&E staff and make them aware of the inclusion/exclusion criteria set for A&E physiotherapy referral.
A Review of 'B3' Breast Biopsies and their Management	• Suggest presenting findings to MDT members to agree on terminology and ensure consensus on management amongst all participants
Evaluate the efficacy of injection therapy in the management of patients with subacromial, shoulder, knee and lateral hip pain in primary care setting	• Shorter follow up (e.g. 6 weeks). • Consider MCID of 1-2 based on a review of the literature. • Annual peer review for training and competency assessment • Shorter follow up. • Annual peer review for training and competency assessment • Continue to audit injection service for efficacy and adherence to PGD guidelines - target 100% •
Anti D / ffDNA compliance in RhD negative pregnant women during 2019	• Share the finding with the Midwives to raise awareness that by having the ffDNA test the patient may not need to have anti-D. • Discontinue sending cord samples from babies where there is a predicted Rhesus type for the baby by ffDNA testing. • Re-audit
Audit of adequacy of magnetic resonance imaging of the shoulder	• 100% of the images should have adequate coverage as depicted by the ESSR guidance. All shoulder MRIs within a 2-month period will be reviewed after 3 months, to assess if these measures have been acknowledged. • 100% of the images should have the use of correct imaging planes as depicted by the ESSR guidance. All shoulder MRIs within a 2-month period will be reviewed after 3 months, to assess if these measures have been acknowledged. • All patients should coverage as depicted by the ESSR guidance. All shoulder MRIs within a 2-month period will be reviewed after 3 months, to assess if these measures have been acknowledged.
Corporate Support Services	
Diagnostic Policy	• Process for each diagnostic department to alert a clinician on immediately life-threatening and high-risk results to be included in the Diagnostic Policy • Review Diagnostic Policy • Disseminate safety message to clinicians at clinical handover meetings; include in doctors' induction training • Specialty leads of each CBU to complete SOP template for diagnostic testing process • Modify audit tool as per recommendations and re-audit in 6 months
Staffing escalation policy	• Share with Senior Nurse team
Delegated Consent Policy	• Institute Consent e-Learning and completion of training • Liaise with • Learning and Organisational Development – to monitoring e-Learning for permanent staff • Medical Education – to monitor e-Learning for Trainee • Specialty/CBUs to include compliance to Delegated Consent

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
	policy in their governance • Governance Department- to include compliance to Delegated consent policy in their dashboard • Liaise with various departments – Procurement, ESR, IT, Clinicians to explore the feasibility to progress to Digital Consent
WHTH Falls Policy	• To update the multifactorial risk assessment to include time of completion in order to determine completion within 6 hours of admission. • Speciality matrons to review their own clinical areas to look at fall's prevention equipment available enhanced care risk assessment completion with the assistance of clinical education and the patient safety team. • Repeat falls policy audit bi-yearly to monitor compliance • Speciality matrons to spot check compliance on lying and standing blood pressure to improve compliance and feed back to Operational safety group • Ensure each inpatient area has a regular supply of patient information leaflets, yellow wrist bands and bed board magnets as part of the fall's prevention equipment • Remove the ability for wards to order clip and cord version of falls alarm • Phased replacement of clip and cord prevention device throughout clinical areas • Themes and recommendations from this audit should be shared via the operational safety group and through high level briefing providing assurances at the Patient Safety and Clinical Effectiveness Sub-Committee. • To ensure all staff have read and are compliant with the most recent trust policy for Prevention and Management of Slip, Trip and fall and the safe use of Bedrails with adult patients. • Audit results to be included on trust induction falls training and updates.
Enhanced Care Policy	• Reinforce the requirement through WHH Nursing & Midwifery Forum and lead nurse meeting. • Disseminate the enhanced care audit report along with the enhanced care policy for information and action • Reinforce the process through weekly harm meetings and daily oversight by matrons and lead nurses • Undertake a chief nurse walk around to focus on enhanced care and falls prevention strategies • Re-audit in 6 months
Digestive Disease's	
Management of Acute cholecystitis - the hot gallbladder pathway	• Encourage the performance of hot cholecystectomy and discuss in monthly surgical meetings the compliance
Optimisation of the patient's haemoglobin prior to surgery by the pre op assessment unit	• Present findings to Anaesthetics and Surgeons to raise awareness of selecting FBC plus and acting on the results and to address IDA at the initial consultation. • Amend Anaemia Pathway, raise awareness of the need to treat

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
	with oral/IV iron, transfuse as per national guidance and for patients who had significant blood loss to discharge the patient with a course of oral iron.
Peri operative WHO checklist - completion of post-operative debrief	• To disseminate via theatre manager (Mark Rigby) to all theatre staff. Increased vigilance in performing theatre debrief, especially in maternity and emergency theatre. • In emergency theatre aim to debrief at the end of each case rather than at the end of the list. • Re-audit approximately yearly and to include weekend lists.
The use of cell salvage in theatres	• During the training and update procedure for members of staff operating the cell salvage machine, we will highlight the indications for the use of cell salvage and the importance of good documentation so that the type of surgical case it was used for can be identified
Decision to delivery times	• None required
Pain management in relation to hip fracture	• Ongoing training via our rolling education programme regarding use of Abbey Pain charts for those admitted with cognitive impairment. • Ensure A&E are aware of this training • Development of #NOF order set on EMPA and to have it uploaded onto the EMPA system. • Dissemination of the order set to A&E/anaesthetists/theatre nursing staff/ward nursing staff • Audit to be developed in 6-12 months' time following
Selective NELA data entries and patient care	• Issues with documentation recognised. Anaesthetists to be informed through presentation, email and personal reminders • Re-audit to check compliance
PEG insertion	• Discuss with IT to bring up a form on Lorenzo • Organise follow up by trained endoscopy nurse specialist team
Re-audit: Obstetric Anaesthesia Follow Up	• Department needs to look into the system of follow up on Lorenzo. • Satisfaction survey once the department has looked into the system of follow up on Lorenzo • Audit of my personal practice part of (not a registered clinical audit)
Elderly Patient Audit in Emergency Theatre	• To enlist the routine postoperative review of these patients by members of the Elderly Medicine team. This does not currently take place
Follow up after presentation with acute diverticulitis	• Patients with suspected complicated diverticulitis should be offered IV antibiotics: Compliance could be further increased by providing further training of guidance to doctors who are clerking patients in A+E. • Patients with collections >3cm should be offered IR drainage. This is currently not happening a lot as patients are being offered other kinds of surgical intervention. Further research may be required to establish which procedures have the best outcomes for these patients. • Patients who have not had previous colonic exploration in the

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
	preceding 18 months should be followed up after an episode of acute diverticulitis. There was some debate between consultants on this topic, however it was decided that these patients should be followed up. A more unified approach from the consultants should lead to improvement in patients receiving appropriate follow up
Retrospective audit of initial diagnostic evaluation and management of spontaneous bacterial peritonitis in ascites of cirrhotic patients by the on call medical team on admission to Warrington hospital'	• Feedback to all clinicians on medical on-call rota highlighting areas of low compliance and gentle reminder/ awareness about BSG standards
Integrated Medicine & Community	
Medication **reviews on the Frailty Assessment Unit**	• Adjustments to FAU proforma to be made
Medical Care	
Bone health assessment for all RA patients (2nd cycle)	• All RA patients review in follow up clinic should have annual bone health assessment.
Management of severe hyponatraemia (re audit)	• Present results in Audit meeting • Junior Doctors teaching session • Order set on ICE for hyponatremia investigation.
Applying NEWS 2 to COVID-19 patients that went on to require critical care admission.	• Continued Support from clinical education team to circulate single point lessons to all staff again, demonstrating humidified oxygen and oxygen devices in addition to device codes. • Dissemination of the results of this audit to ward managers/ matrons and lead nurses re; importance of documentation on the reverse of the NEWS2 chart as per policy. • Continue trust wide roll out of e- observations • Re-audit of same cohort of patients during the second wave of Cocid-19
Blood glucose monitoring	• Education Ward staff of BG recommendations • Adjust data collection sheets • Audit patient contacts to see if BG frequency mentioned • Education Ward staff of BG recommendations • After education re-audit BG monitoring • When patients with diabetes reviewed DSN/Medical staff to ensure Gold score completed. See Gold audit
NEWS2	• Implementation of weekly local audits on the following wards, A1, ED, A5, A7, A8 and B14 reporting to lead nurse. • The progress against this standard will be managed in the CBU and report on the ward local action plan • Acute Care Team are supporting wards with on-going 24/7 availability and training. • Training resources and single point lessons to support staff shared with the senior nursing team • The progress against this standard will be managed in the CBU and report on the ward local action plan

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
	• Ward managers, matrons and lead nurses to provide area-specific ward action plans to address specific local failings • The progress of achievement on the action plan will be managed in the CBU and reported to the Nursing and Midwifery Forum meeting and the CBU Governance meeting • To discuss the potential for early roll-out of E-Observations throughout further pilot areas
"CT or not CT: That is the question. Do drug overdoses admitted to ICU need a CT scan?"	• None required
The management of acute pancreatitis in an intensive care unit of a district general hospital	• F1 teaching sessions on acute pancreatitis • F2 dedicated teaching session on acute pancreatitis • New pancreatitis order set on ICE • New Acute Care Team Referral for pancreatitis • Formal inclusion of this cohort of patients in Critical Care Outreach Ward Round • Standard met • Standard met • F1 teaching sessions on acute pancreatitis • F2 dedicated teaching session on acute pancreatitis • Not studied • Standard met • Liaise with General Surgical and Gastroenterology Consultants • F1 teaching sessions on acute pancreatitis • F2 dedicated teaching session on acute pancreatitis • Liaise with Radiology Consultants • Liaise with Gastroenterology Consultants
Nadia Harms	• Review peri-operative guidelines to make continuation background insulin clearer • NADIA Harms – present 6 monthly at diabetes audit • Educate ED around BG checks post hypoglycaemia •
Surgical Specialities	
The prevalence of tonsil cancer in patients who have been admitted with peritonsillar abscess	• No action required
ENT outpatient clinic numbers - Compliance with National Guidelines (Re audit against 189)	• Clinic templates to be altered • Removal of JT.ENT slots • Re-audit post April 2020
Outcomes of surgery in COVID-19 infection: international cohort study (CovidSurg)	• Keep reviewing data in all COVID positive NOFs and apply standard precautions as per microbiology advice
Compliance to Local and NICE Guidelines of Glaucoma in the MDT Glaucoma Team	• To make virtual review safe. Dedicated visual field machines and NIDEK gonioscope to be secured • Implementing new clinic templates for the glaucoma service
A&E to Fracture clinic referrals: Are we compliant with BOAST	• Create T&O guide • Ratification of SOP in T&O governance meeting and

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
guidelines? (Pre-COVID)	implementation of guide • Re-audit after implementation of guide
Integrate Covid-19 ENT Emergency Care Audit	• The new ENT UK COVID-19 guidelines for management of epistaxis and tonsillitis/quinsy are safe for continued use by ENT department
Discharge Summaries	• Present findings at departmental governance meeting • Re-audit following dissemination of agreed recommendations • Present findings at regional / national oral surgery conference training day
Factors affecting length of stay for neck of femur fractures 2nd cycle	• Cancellation of elective lists if NOF fracture patients waiting for >33 hours for operation
Stroke Service Review	• Cross check database to ensure all patients accounted for • MediSIGHT audit trail/check • To share audit with Geriatric medicine team to increase awareness and improve communication regarding outliers at Warrington • Continue to offer all patients an assessment
British Society of Otology: Otological surgery registry during COVID-19	• None
Management of tonsillitis	• Discussion with ENT and pharmacy regarding whether current practice is acceptable against BMJ best practice guidelines and BNF • Discussion with pharmacy & ENT seniors about potential order sets to guide clinicians prescribing and with ENT about the importance of this and if it warrants a WHH guideline being completed.
Refractive Outcome Following Cataract Surgery	• Staff to input data from post op check
NICE guidelines for Neck of Femur Fracture CG124	• Continue same, Re-audit in 2021 • Operative notes to indicate justification for choice of implant • Re-audit in 2021 • Re-audit in 2021 • Continue two Orthogeriatrician service • Consider employment of full time Physician associate • Re-audit in 2021
Recording mental capacity in patients presented with neck of femur fracture following introduction of NOF pathway in fifty patients.	• Have discussed with Trauma nurse coordinator to bring it forward to the editors of the NOF pathway to create prompt to fill in AMTs if not filled in/left blank • Present audit at audit meeting
Are we data safe while in hospital	• Education- Spread the message via common email, IT Training, Stickers on Computers
Compliance with acute back pain SOP	• Inform ED Staff of non-compliance and request them- Email • Inform ED and T&O of the guideline and what it requires in terms of documentation • Display a printout chart of the guidelines in ED • Teaching, Display guideline

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
The management of ankle fractures presenting to Warrington A&E	• To improve staff training and awareness of the immobility required in unstable ankle fractures by the development of a poster for presentation in the Minor Injuries Unit. A re-audit will then be performed to assess if this has been successful in reducing the number of patients with unstable fractures inappropriately immobilised.
Audit of Audits	• Consider creating educational module on audits and process at WHH with a video presentation/PowerPoint show for trust induction • Departmental induction: Creating real- time list of audits and available audits • Consider requesting adding a section on registration form for Governance lead approval and instruction that they be copied into the email when registering with the clinical audit department • Consider a section in audit registration form for Stakeholder inclusion in audit registration, process and presentation • Departmental named folder for storage of Audit data • Scoring for audit system and re-audit with the scoring • “Audit of orthopaedic audits” to be made an ongoing loop
Supracondylar fractures in Children – Audit on Neurovascular documentation	• Education of doctors during induction • Poster for awareness • Poster for awareness • Re-audit in September 2022
Covid 19 cases in CSTM	• None
Listing for Lower Third Molar Removal – Are We Conforming to The Norm Part 2 - Re audit	• Non required – department 100% compliance
Sedation in oral surgery	• Organise yearly IV sedation training for appropriate members of staff. This ensures that 12 hours of CPD training is obtained in each 5-year cycle as per Intercollegiate Advisory Committee for Sedation (IACS) in Dentistry guidelines
Urgent and Emergency Care	
Comparison of the use of the COVID Assessment Note by ED and specialty teams at WHH (April/May 2020)	• Feedback to FY1 and FY2 doctors the results of the re- audit (to be completed by Dr Ali and Dr Graham - July 2020) • Feedback to consultant staff in A&E (to be completed by Dr Robinson -July 2020) • Introduction of COVID clerking documentation at junior doctor induction training (to be completed by Dr Roy Bhati and Dr Nadeem Ashraf –September 2020) • Audit of escalation status and patient outcomes (to be completed by Dr Saagar Patel – September 2020)
VTE prophylaxis in lower limb injuries	• Educate staff, strict compliance with departmental guidelines aligned with nice guidelines for vte
Prescribing of antibiotics for asymptomatic bacteriuria in pregnancy	• Raise at A&E safety brief to remind staff that MSU should be sent in these cases Discussion with A&E team to determine most practical way for this to be done

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
Women's and Children's	
SGA and FGR Detection	• Either implement sBL2 e learning or GAP training To review rates In keeping with SBL 2 FGR policy
Clinic Outcomes DNA and Cancellations rates 2019-2020	• No actions
Antenatal Screening Satisfaction Survey	• Implementation of the use of the PHE digital links to improve engagement with women at first contact with the maternity services • Dissemination of points raised from survey surrounding poor comments through the ANNB Screening update as part of the Midiwfery Mandatory Training update • Repeat of survey in October 2020 with modification of some questions
Post-Partum Haemorrhage	• Dissemination information: email to all midwifes and doctors • Dissemination information: email to all midwifes and doctors • Scales have been ordered for each LW room and theatres • Dissemination information: email to all midwifes and doctors • Change guideline to all Wales Policy • Re-audit in 3 months after changes implemented
Paediatric and Neonatal Handover Audit and Quality Improvement Project	• Switch board asked to change timings of test bleeps. Nursing staff and A&E staff to be made aware of handover timings and asked not to interrupt unless in an emergency. • Nurse co-ordinator to be asked to attend the handover • Handover checklist developed and incorporated into handover practice to include safety brief (system risk assessment) • Staff reminded to attend handover on time and to do a focused handover using SBAR format and avoid unnecessary conversations during handover
Cannulation dressings	• No further actions were identified, this was a repeat audit and mitigations put in place are working effectively
Surveillance and management of hyperplasia	• Patient information leaflet to highlight importance of management as well as surveillance • Ensuring enough staff available in clinic to facilitate up-to-date patient BMI to allow for improvement in documentation of risk factors
Paediatric and Neonatal Handover Audit and Quality Improvement Project - Re audit	• No specified actions.
Audit of Prevention of Early onset Group B Streptococcal Infection in Neonates	• Re audit in 6 months • Highlighted to all midwifery staff poor rates of MSSU being received at booking
CTG monitoring in Intrapartum women requiring CTG	• Computerised Records on IT System • Ensuring someone is assigned to complete fresh eyes • Educating foundation doctors and GPSTs on basis of CTG

Local Audit Title	Quality Improvement Action Plan
Clinical Support Services	
	• Hiring more staff • Re Audit
Do postnatal women with gestational hypertension get offered follow up?	• To ensure all women with hypertension in pregnancy have a follow up after 6 weeks postpartum

2.9 Participation in Clinical Research and Development

The number of patients receiving NHS services provided or sub- contracted by Warrington and Halton Teaching Hospitals NHS Foundation Trust in 2020/21 recruited to participate in research approved by a research ethics committee was 1,879.

In 2020/2021 the Trust were delighted to open the Halton Clinical Research Unit (HCRU), within the Nightingale Building on the Halton site at Runcorn, which will provide opportunities for people in Halton, Warrington, Cheshire and Merseyside to participate in clinical trials and research close to home.

The Trust has been working with the National Institute for Health Research (NIHR), Clinical Research Network North West and Liverpool University Hospitals NHS Foundation Trust (LUHFT) to further develop its research and investigation capability. In 2020/2021 we were delighted to have commenced the first clinical trial, a COVID vaccine trial on Ward B1.

The unit was officially opened on Thursday 4th March by the Trust's Chairman along with partners. HCRU will provide flexible accommodation and staff to support different types of clinical research and trials.

This investment in the Halton Hospital site is a further demonstration the Trust's commitment to the further development of its research and investigation capacity, supported by the Quality Academy's Research and Development Team. It provides an exciting opportunity for local people and for WHH staff and is pivotal to supporting continual improvement of services provided by the Trust.

2.10 The CQUIN Framework

The Commissioning for Quality and Innovation (CQUIN) framework forms one part of the overall approach on quality, which includes: defining and measuring quality, publishing information, recognising and rewarding quality, improving quality, safeguarding quality and staying ahead.

The aim of the CQUIN payment framework is to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. The framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing the commissioners to link a specific modest proportion of providers' contract income to the achievement of locally agreed goals.

A proportion of Warrington and Halton Teaching Hospitals NHS Foundation Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between Warrington and Halton Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2020/21 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/

The Trust did not sign a new contract in 2020/21 and rolled forward the 2019/20 contract in line with NHSE mandate due to COVID.

2.11 Care Quality Commission (CQC) Registration

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 2020/21.

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 by the Care Quality Commission during 2020/21.

2.12 CQC Engagement

The Trust has not been inspected during 2020/2021. The CQC adapted their regulatory approach to a Transitional Regulatory Approach with a focus on engagement meetings and assessments against the CQC's interim assurance frameworks. In 2020/2021 the Trust has:

- Been assessed against the Emergency Support Framework for Infection, Prevention and Control and deemed fully compliant.
- Participated in a Provider Collaboration Review to assess Collaboration in Urgent and Emergency Care across Cheshire and Merseyside. The Trust received positive feedback following this review and were recognised in the national report as offering a good example of collaboration for our work supporting patients with mental health needs (Core 24 provision).
- Been assessed in Urgent and Emergency Care using the CQC's Patient FIRST framework. Positive feedback was received following this review.

Post CQC Inspection Activity

The Trust was given an overall rating of **'Good'** by the CQC in 2019. The action plan following this inspection was completed in November 2020. The Trust is currently focusing on workstreams to support the Trust to 'Move to Outstanding', in line with our Moving to Outstanding agenda.

2.13 Trust Data Quality

Warrington and Halton Teaching Hospitals NHS Foundation Trust submitted anonymised clinical data for patients seen and treated during April – February 2020/21* to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics.

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
Admitted Patient Care	99.9%	99.5%	Apr 2020 – Mar 2021
Outpatient Care	100%	99.7%	Apr 2020 – Mar 2021
A&E Care	99.4	97.9	Apr 2020-Dec 2020

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
Admitted Patient Care	100%	99.8	Apr 2020 – Mar 2021
Outpatient Care	100%	99.7%	Apr 2020 – Mar 2021
A&E Care	100%	98.8%	Apr 2020-Dec 2020

*provided from SUS – Cumulative year to date to Feb 2020/2021

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 was launched in 2019/20 and has further supported the monitoring of data capture completeness.
- The Data Standards and Assurance Group focusses 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, this 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 that includes role-based responsibilities for data quality and is reviewed on a routine basis to ensure that it supports reporting and statutory obligations around national datasets.

2.14 Information Governance

The Trust uses the Data Security and Protection Toolkit in conjunction with the Datix Risk Management system to inform the work of its Information Governance and Records Sub-Committee. The Information

Governance and Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the Trust Board.

The Trust's Senior Information Risk Owner (SIRO) chairs the Information Governance and Corporate Records Sub-Committee which is also attended by the Trust's Caldicott Guardian. The SIRO (Executive Medical Director) acts as the Board level lead for information risk within the Trust. Any areas of weakness in relation to the management of information risk which are identified, or are highlighted by internal audit review, are targeted with action plans to ensure that we continue to strive to be information governance assured. The Trust's most recent assurance level, awarded in 2020 after review of the Trust's Data Security and Protection Toolkit submission, was Substantial Assurance.

The Trust has undertaken a data security and protection readiness review audit in conjunction with Mersey Internal Audit Agency in February 2021. The 2020/21 DSPT baseline submission is scheduled to take place in line with NHS digital policy by June 30th, 2021. The internal audit readiness review concluded that "*the governance structure demonstrated to monitor the Trust's DSPT submission was clear and ensured oversight at Executive and Non-Executive level*".

2.15 Clinical Coding/Payment by Results (PBR)

Warrington and Halton Teaching Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2020/21 as they are no longer routinely undertaken within the NHS.

Warrington and Halton Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality;

- Continuous engagement with clinicians to improve documentation and clinically coded data.
- Working with clinicians to migrate from handwritten to digital operation notes.
- On-going programme of internal clinical coding staff audits.
- Supporting the mortality review group with documentation and clinical coding reviews.
- Continuous training and updating of skills for clinical coders.
- Targeted specialty documentation and clinical coding audits.
- Collaboration with Informatics to enhance the usability of Lorenzo to improve the coding process.
- Highlight data quality issues for resolution to the Application Support Team.

2.16 Learning from deaths

In March 2017, The National Quality Board 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 meeting. This data should include the total number of the Trust's 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 which is now 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 has currently trained 10 clinicians 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 and 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 & Clinical Effectiveness Sub-Committee monthly.

By 31st March 2021, 203 SJRs were completed. 2 investigations (Serious Incidents) were carried out in relation to 1,274 of the deaths. They occurred in each quarter of that reporting period as follows:

- Quarter 1 - 58 SJRs completed and 0 Serious Incidents
- Quarter 2 – 50 SJRs completed and 1 Serious Incident
- Quarter 3 - 55 SJRs completed and 0 Serious Incident
- Quarter 4 - 40 SJRs completed and 1 Serious Incident. 2 cases were also subject to both an SJR and Concise Investigation)

In order to support learning across the Trust human factors training has been undertaken in accordance with findings of Trust internal intelligence to continually drive the standard of care delivered to patients.

This provides valuable feedback on all aspects of care and helps us to understand what we may need to improve and equally what has been effective and meaningful for our patients. In addition, quality improvement leads are now invited to mortality review group to triangulate themes identified with quality improvement initiatives.

Due to the COVID-19 Pandemic the Learning from Deaths event and Patient Safety Summit to share learning over the past 12 months had to be paused. This will be reconvened in 2021.

2.17 Core Quality Indicators 2020/21

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 the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed 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.

2.18 Summary Hospital-Level Mortality Indicator (SHMI)

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

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
November 2019- October 2020 NB: At the time of writing this report this is the most recent SHMI	106.9	2	117.75	67.82	100
November 2018 - October 2019	106.89	2	120.12	68.48	100
October 2018 – September 2019	105.93	2	118.77	69.79	100
October 2017 – September 2018	109.92	3	126.81	69.17	100
July 2016 – June 2017	112.32	2	122.77	72.61	100

NB: This information is re-based so there may be a variation from HED monthly reporting and details the 2019/20 national comparative data available at present. **https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/shmi-data**

NB COVID-19 was 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, in that 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 (HED) benchmarking system to facilitate further analysis. 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 were categorised 'as expected' over the past 12 months.

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 the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. 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.

Mortality ratios are complex indicators and there are multiple factors that contribute to the overall score, including the quality of our documentation and coding.

We 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 CBU's on their allocated audit days.

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.

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

3. DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
November 2019- October 2020 NB: At the time of writing this report this is the most recent data	45%	36%	59%	8%
November 2018 - 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%

https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/palliative-care-coding

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that 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 intends to take the following actions to improve the rate and so the quality of its services by investigating the detail behind the ratio numbers. We identified that our rate of service provision was the lowest in the North West prior to 2012/2013, and we have worked hard to now be in a position in which we compare favourably with local peers. The Trust has improved over the years to a steady rate, which is comparable with the England average. However, we continue to prioritise the coding of patient deaths to ensure that they are coded correctly as palliative care. Clinical Coding attend MRG meetings to support with ensuring that the coding is also appropriate.

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

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

This data is made available to the Trust by the Health and Social Care Information Centre 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	Hip replacement	Knee replacement
Year	**Level**	**Average health gain**	**Average health gain**	**Average health gain**
2019/2020	Trust	*	0.474	0.353
2019/2020	England	*	0.459	0.335
2018/2019	Trust	*	0.500	0.324
2018/2019	England	*	0.456	0.336
2017/2018	Trust	0.019	0.341	0.312
2017/2018	England	0.089	0.488	0.345

		Groin hernia	Hip replacement	Knee replacement
Year	Level	Average health gain	Average health gain	Average health gain
2016/2017	Trust	0.036	0.455	0.370
2016/2017	England	0.086	0.444	0.324

*2020/2021 and Groin hernia information for 2018/19 or 2019/20 data is not available at the time of reporting. https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that the PROMs data is a nationally agreed dataset. The data is collected, processed, analysed and reported to the Health and Social Care Information Centre 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. The Health and Social Care Information Centre is responsible for scoring and publishing of PROMs data, as well as linking it to other data sets such as Hospital Episodes Statistics. In 2021/22 this will be monitored via the Patient Experience Sub-Committee.

2.21 Emergency readmissions to hospital within 28 days of discharge

NB: This data is not available on HSCIC and the technical specification for the dataset is not available so the Trust cannot replicate the data using local information.

It has been acknowledged that an error was made in the drafting of the regulations and that the split of patients for this indicator should be

0 to 15; and

16 or over,

This indicator on the HSCIC Indicator Portal was last updated in December 2013 and the proposed update that was due to take place in August 2016 was postponed, therefore there is not up to date information.

2.22 Percentage of staff who would recommend the provider to friend or family needing care

The data is made available to the Trust by the Health and Social Care Information Centre via the National NHS Staff Survey Coordination Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

Staff who would recommend the provider to friends or family needing care by percentage*

DATE	TRUST	ACUTE TRUST
2020*	71.3%	74.3%
2019	65.2%	70.5%
2018	60.7%	71.2%
2017	59.5%	70.6%

http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_RWW_full.pdf * 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*'.

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2020 national NHS staff survey conducted by Quality Health on behalf of the Trust. Quality Health utilises high quality research methodology and mixed method collection resulting in a 36% response rate compared to the Acute Trust Average of 45%. This represents 1,492 staff responding to this survey.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has several work streams in place to improve this score, evidenced by the year on year improvement from 2015 onwards. The Trust embrace staff-led change through the 'Be the Change' Team, supporting our workforce to identify and deliver improvements for our patients. The Trust's Quality Academy also supports our workforce to utilise Quality Improvement methodology to implement change. This has had additional investment in 2020.

2.23 Percentage of admitted patients' risk-assessed for Venous Thromboembolism

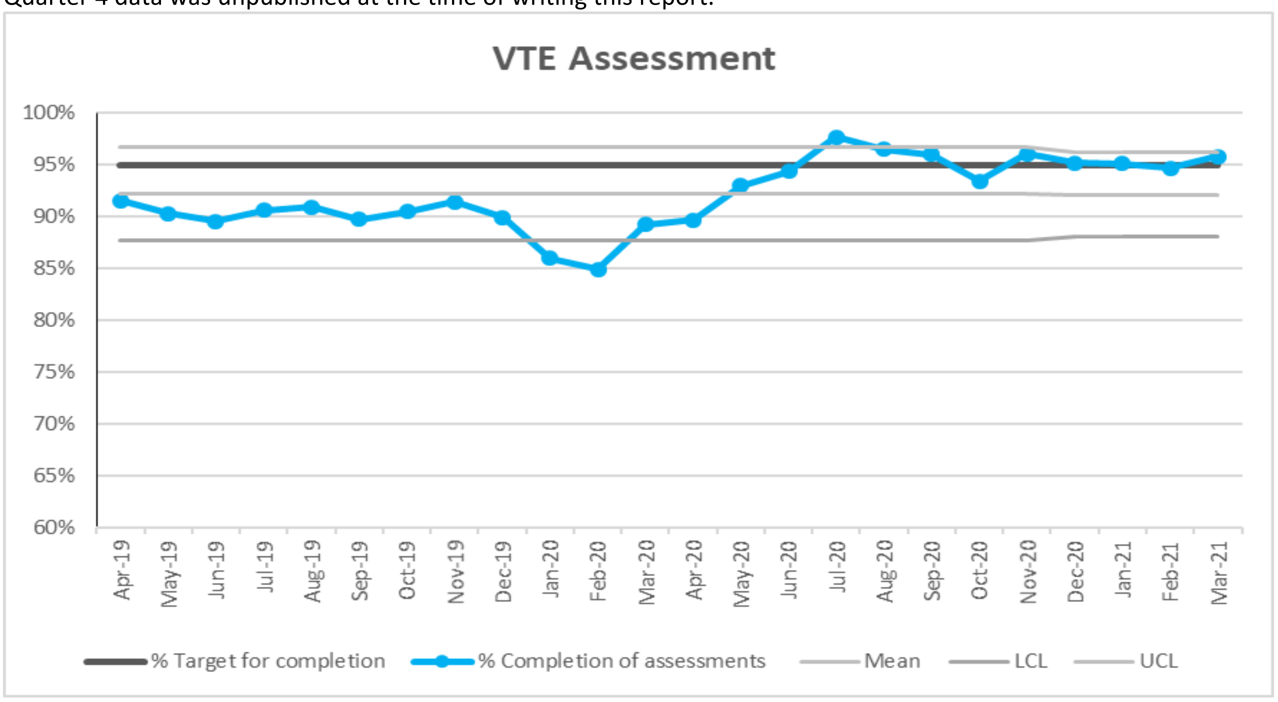
The data made available to the National Health Service Trust or NHS foundation Trust by the National Commissioning Board with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. There has been a slight reduction in performance as noted below, due to the ongoing COVID Pandemic. However, this is now steadily increasing (see SPC below)

Venous Thromboembolism (VTE) – percentage of risk assessments undertaken

Year	Q1	Q2	Q3	Q4
2020/2021	92%	97%	95%	*
2019/2020	90.45%	90.38%	90.60%	87%
2018/2019	95.76%	95.02%	95.03%	95.58%
2017/2018	95.18%	95.88%	95.24%	95.62%

* https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/

Quarter 4 data was unpublished at the time of writing this report.



Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this percentage is as described for the following reasons in that this is a nationally accepted dataset which is submitted to the Department of Health at the agreed frequency.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this performance with focussed work alongside clinical teams to improve compliance with the VTE electronic risk assessment processes. The Trust has aligned the VTE audit process with the GIRFT framework for further oversight on quality.

2.24 Treating Rate of C. difficile per 100,000 bed days amongst patients aged two years and over

The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period. The data includes all cases detected and reported to Public Health England including community onset cases.

Warrington & Halton Teaching Hospitals NHS Trust Clostridium difficile infections per 100,000 bed days

DATE	TRUST REPORTED CASES	RATE	RATE (all reported cases per 100,000 population)
2019/2020	78	43.6	23.5
2018/2019	65	35.9	21.9
2017/2018	55	29.9	23.9
2016/2017	65	34.1	23.3

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data
Annual publication of epi commentary (publishing.service.gov.uk)

England data for 2020/21 not available at the time of preparing this report

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that the data is as described for the following reasons there is a robust system for data entry and validation which ensures all cases are entered onto the Public Health England Data Capture System.

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

- Action plan in place to reduce Clostridium difficile
- Participation in European Antibiotic Awareness Day
- Fidaxomicin used for treatment of patients with recurrent Clostridium difficile infection
- Antimicrobial steering group with feedback to Clinicians on incidences of antimicrobial prescribing non-compliance
- Director of Infection Prevention and Control challenge for antibiotic prescribing non-compliant with Trust Formulary
- Surveillance of cases/monitoring for increased incidences in defined locations
- Improvements to methods of investigation for Clostridium difficile cases
- Increase in ward-based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment and single point lessons on Clostridium difficile and use of SIGHT mnemonic
- Action plan in place to reduce MRSA and MSSA bacteraemia cases

- Revision to post infection review template for bacteraemia cases
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment
- Gram Negative Bloodstream Infection (GNBSI) reduction Group has been set up and there is an action plan in place with a focus on reducing use of urinary catheters, patient hydration and patient hand hygiene
- Urinary Catheter Passport revised and implemented
- 4 additional hydrogen peroxide vapour decontamination units purchased and used for environmental decontamination following discharge of patients with high transmission risk infections

2.25 Patient Safety Incidents

Patient Safety Incidents – Rate of incidents per 1000 bed days

DATE	TRUST	TRUST NUMBER	MEDIAN	LOWEST	HIGHEST
Oct 2019 – Mar 2020	44.3	4045	50.7	15.7	110.2
April 2019 – September 2019	48.69	4272	48.5	26.3	103.8
Oct 2018 – Mar 2019	44.68	3964	44.5	16.9	95.94
April 2018 – September 2018	41.6	3833	42.4	13.1	107.4
Oct 2017 – Mar 2018	38.78	3764	42.55	24.19	124
April 2017 – September 2017	41.07	3619	42.84	23.47	111.69

NB: NRLS Report provides median rate of incidents per 1000 bed days reported by all non-specialist acute Trusts.

Patient Safety Incidents Severe Harm / Death

DATE	TRUST	NATIONAL	LOWEST	HIGHEST
Severe Harm and Death Oct 2019 – Mar 2019	0.2% (9)	x0.3% (Non-specialist acutes only)	0 (0)	1.5 (19)
Severe Harm and Death April 2019 – September 2019	0.44% (19)	0.3% (Non-specialist acutes only)	0% (0)	1.6 (58)
Severe Harm and Death Oct 2018 – Mar 2019	0.45% (18)	0.3% (Non-specialist acutes only)	0.009% (1)	1.8 (42)
Severe Harm and Death April 2018 – September 2018	0.73% (28)	0.3% (Non-specialist acutes only)	0% (0)	1.2 (48)
Severe Harm and Death Oct 2017 – Mar 2018	0.37% (14)	0.3% (Non-specialist acutes only)	0% (0)	1.55% (99)
Severe Harm and Death April 2017 – September 2017	0.64% (23)	0.4% (Non-specialist acutes only)	0% (0)	1.98% (121)

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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that it downloads all incidents via DATIX to the National Reporting and Learning System within the agreed timescales.

Warrington and Halton Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services by:

- The *'Reporting to Improve'* campaign continued 2019-20/2020-21 which actively encourages incident reporting by all members of staff promoting an open and honest culture.
- Continued investigations to the appropriate level dependent upon the severity of the clinical incident reported.
- Continued training for staff to use the Trust online reporting system, Datix.
- Continued support for senior staff with Risk training to assist them when reviewing incidents.
- Improved monitoring of actions from incidents to ensure that they are completed in time in order to improve care for patients and staff.
- Additional scrutiny continues at the Trust Weekly Meeting of Harm.
- The Trust also has in place a Clinical Harm Review panel to support waiting list management.

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.
- Trust wide safety alerts and notifications
- Safety briefings in clinical areas
- Amendments to policy
- Annual Safety Summits
- Daily Safety Huddles
- Trust wide Safety brief
- Monthly CBU and Specialty Governance Meetings
- Weekly CBU Governance Review Meetings between CBU Managers and CBU Governance Managers

2.26 Freedom to Speak Up (FTSU)

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

The Trust has a named Executive Lead, Non-Executive Lead and a FTSU Guardian. In addition, there are over 30 FTSU Champions across the Trust with as many different backgrounds and professions as possible represented. Staff across the Trust can speak up directly to the Guardian or a Champion; they can phone, email or write to FTSU team. If details are shared a member of the FTSU team will get in touch with the person raising the issue and offer a face to face meeting or a chat on the phone. FTSU highlight the purpose of the role 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. The individual can remain anonymous if they wish and we discuss if this is possible and the impact.

The Trust FTSU team completed quarterly national return on activity and reports to the Trust Board twice a year and Committee quarterly.

The Trust has a FTSU policy which is in line with the national policy stating "If you raise a genuine concern (i.e. held in reasonable belief) under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern; in fact any such attempt would warrant you raising a concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action for the person(s) involved. We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police or if it is required to be disclosed for the purposes of subsequent disciplinary action). You can choose to raise your concern anonymously, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome."

Freedom to Speak up links to the QPS aims and objectives of the Trust and the activities of the FTSU Team are reported twice a year to the Board and Quarterly to the Strategic People Committee. The number of disclosures are benchmarked against similar Trusts and national guidance is reviewed and implemented. The Trust undertakes the toolkits provided by the national office.

2.27 Seven Day Hospital Services (7DS)

NHS England and NHSI altered their methodology for assessing compliance with the Seven Day Services priority clinical standards which has allowed the Trust to focus on Clinical Standard 2 (CS2) to ensure that it meets the target of 90% of patients having a review by a Consultant within 14 hours of admission by March 2020.

The other three clinical standards have been actioned and maintained over the past two years therefore our improvement focus can be placed upon Clinical Standard 2. Additionally, from April 2019, the Trust made the delivery of an improvement in Standard 2 of the 7 Day Services, which is Time to First Consultant Review, in Paediatrics and General Surgery a quality priority.

Clinical Standard 2 was audited on a quarterly basis during 2019 and 2020, with the data and improvement work focusing upon Paediatrics and General Surgery. Rather than using random samples we used full admissions to both specialities during the audited week as the numbers would have been too small to have provided an accurate result that was representative of the performance against the standard.

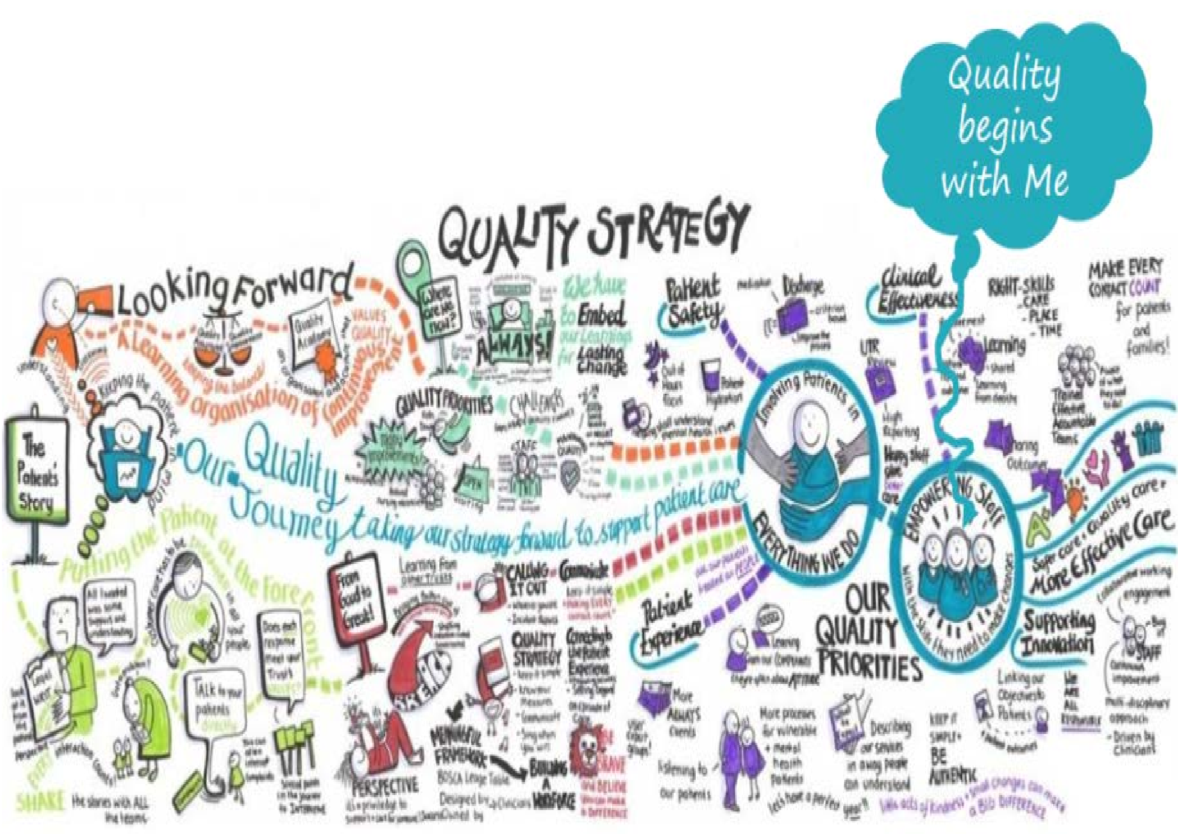
Paediatrics: Paediatrics achieved the required 90% compliance with the standard during the Quarter 3 and 4th quarter audit. In order to test sustainability with the compliance achieved, a further audit for Clinical Standard 2 will be implemented during 2021/22.

General Surgery: General Surgery achieved the required 92% compliance with the standard during the audit. In order to test sustainability with the compliance achieved, a further audit for Clinical Standard 2 will be implemented during 2021/22.

Part 3

4. Review of Quality Performance

Patients are at the centre of everything we do and providing high quality service for every one of our patients is at the heart of our organisation.



3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

Our aim is to be a learning organisation that consistently transforms practice by continuous learning in order to provide the best possible health care. The Trust's vision is that we will be the change we want to see in the world of health and social care.

To support our overall aim we have developed a Quality Strategy to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

The Quality strategy has been developed based first and foremost to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be. With the above care model in mind we use the following three priority domains:

3.2 Quality Priorities on a page

OUR 2021-22 QUALITY PRIORITIES

The improvement aims	The quality priorities	The outcome
IMPROVE PATIENT SAFETY	1. DNACPR - improving communication with patients and families 2. COVID-19 recovery - robust waiting list management with senior clinical oversight 3. Gram-negative bloodstream infections - achieving a 5% reduction	A safety and learning culture where quality and safety are everyone's priority
IMPROVE CLINICAL EFFECTIVENESS	4.Medical Examiner - embedding the service and piloting community roll out 5.Evidence based interventions - effective decisions based on the best evidence 6.CBU governance - strengthened and consistent across the organisation	Doing the right things, the right way, to achieve the right outcomes for our patients
IMPROVE PATIENT EXPERIENCE	7.End of life Serious Illness Programme - improving care and communication 8.Learning disabilities and mental health - implementing and embedding our strategy 9.Nutrition - To ensure that patients have access to a choice of food and nutrition.	Patient experience at the heart of all we do, seeing the person in the patient

3.3 Data Sources

Intelligent information is collated from, whenever possible, sources which can be benchmarked with other organisations in order to indicate the Trust's performance in relation to others. The Trust submits and utilises data from the Health and Social Care Information Centre (HSCIC) which includes for example Patient Reported Outcome Measures (PROMs) in England whereby patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS are asked to complete questionnaires before and after their operations to assess their perceived improvement in health.

The Trust also subscribes to Datix, which is web-based patient safety software for healthcare risk management. It delivers the safety, risk and governance modules which enable the Trust to have a comprehensive oversight of our risk management activities including incident reporting and complaints, compliments, comments and concerns.

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 o der to improve patient care.

The Trust submits data to the NHS Safety Thermometer which was developed as a point of care survey instrument, providing a 'temperature check' on harm that can be used alongside other measures of harm in providing a care environment free of harm for our patients. The Trust undertakes a monthly survey on one day of all appropriate patients, to collect data on pressure ulcers, falls, urinary tract infection (UTI) in patients with catheters and VTE. The Safety Thermometer measures the percentage of patients who have experienced harm in relation to any of these issues and allows the Trust to identify weaknesses; make changes to practice and measure improvement.

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

3.4 Quality Dashboard 2020/21

The clinical indicators in the Quality Dashboard have been reviewed in line with the revised requirements for 2020/2021 in relation to the:-

- CQUINs – National (paused at present)
- NHSI KPI
- 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 and reporting to the Quality Committee to provide assurance on progress. 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 has received an integrated performance dashboard which triangulates workforce, quality and financial information.

3.5 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the Trust based on performance in 2020/21 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 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.

The quality indicators for 2020/21 can be seen below and have been reported in section 2 of this report:

Patient Safety Domain

- Gram Negative Bloodstream Infections - A 5% reduction in Gram Negative Bloodstream Infections (GNBSI)
- A 10% reduction in the overall number of inpatient Serious Harm Falls
- Deteriorating Patient - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions

Clinical Effectiveness Domain

- Implementation of the Medical Examiner role into the Trust
- Demonstrate that health care is based on the best available, current, valid and reliable evidence from GIRFT and NICE
- CBU Governance to be strengthened, to ensure that CBU Governance is embedded and consistently and effectively applied across all areas

Patient Experience Domain

- Implementation of the End of Life Serious Illness Programme
- Development and implementation of the Trust Learning Disability Strategy
- Reduce deconditioning and PJ Paralysis

3.6 Parliamentary and Health Service Ombudsman

The PHSO is a free and independent service, set up by Parliament. Their role is to investigate complaints were individuals feel they have been unfairly treated or have received poor service from government departments; other public organisations and the NHS in England. The PHSO make the final decision on complaints about public services for individuals.

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (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 over the year within the Trust.

	Apr 20	**May 20**	**Jun 20**	**Jul 20**	**Aug 19**	**Sep 20**	**Oct 20**	**Nov 20**	**Dec 20**	**Jan 21**	**Feb 21**	**Mar 21**
PHSO cases received	0	0	0	0	0	1	1	1	0	0	0	0
PHSO cases closed	0	0	0	0	1	0	3	0	1	0	1	0
Ongoing PHSO Cases at the end of 2020/21 = 3												

3.7 National Survey Results 2020 - National Inpatient Survey 2020 (published but under embargo, date to be confirmed)

Listening to patients' views is essential to providing a patient-centred health service. The annual National Inpatient Survey is a Care Quality Commission (CQC) requirement with the aim of obtaining feedback to improve local services for the benefit of the patients and the public. Survey results are reported to the CQC, who use the information as part of the Hospital Intelligent Monitoring. Patients are eligible for the survey if they are aged over 16 years or older, and have spent at least one night in hospital, and were not admitted to maternity or psychiatric units.

The 2019 Inpatient survey was undertaken by Quality Health, on behalf of the Trust and covers all aspects of patient's admission, care and treatment, operations and procedures and discharge from hospital from the inpatient specialties of General Surgery; Urology; Trauma and Orthopaedics, Cardiology, Acute Internal Medicine, Stroke and Respiratory Medicine. The initial results of the Inpatient Survey (2020) will be received in June 2021 and are therefore not included at the time of writing this report.

The 2019 Inpatient survey included a sample size of 1250 consecutively discharged inpatients, working back from the last day of July 2019. The final response sample was 1194 due to changes in respondent's

circumstances such as not known at address or deceased. The target response rate is 60%; Trust response rate was 40%, a reduction from 2018 response rate (41%).

The NHS Inpatient survey provides the Trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.

The Picker Institute coordinates all the national results on behalf of the CQC, who publish reports which include benchmarks against performance. Seventy-six questions are asked and categorized into twelve domains as follows:

- Admission to hospital – no
- A&E Department
- Waiting List and Planned Admission
- All types of Admission
- The Hospital and Ward
- Doctors
- Nurses
- Your Care and Treatment
- Operations and Procedures
- Leaving Hospital
- Overall views on care and Services
- About you

The following are examples of improvement for 2019 benchmarked against 2018 results using the suppressed standardised data provided by Quality Health. 2020 data is not yet available at the time of this report.

The Trust has improved by 5% or more on the following questions: Results- *Higher is better*		
Question	**2018**	**2019**
If you brought your own medication with you to hospital, were you able to take it when you needed to? Yes, always	50%	55% ⇧
Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)? Yes, always	73%	78% ⇧
Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)? Yes, always	82%	87% ⇧

Some scores for Warrington and Halton Teaching Hospitals NHS Foundation Trust are in the intermediate 60% range of Trusts surveyed by Quality Health. Warrington and Halton Teaching Hospitals NHS

Foundation Trust considers that this data is as described for the following reasons, central to the Trust ethos is the view that patients deserve high-quality healthcare, and patients' views and experiences are integral to successful improvement efforts. As such it employs Quality Health to undertake a robust and comprehensive survey of patients experience on an annual basis.

The Ward Accreditation Scheme within the Trust will continue to support improvements and to engage staff and empower leadership capability ensuring that we deliver the highest standards of healthcare for our patients.

The National Inpatient Survey key themes had been reviewed in full and have been scrutinised. There has been significant work undertaken by the CBUs, with the implementation of the five work streams of the Patient Experience Strategy, led by Lead Nurses and Allied Health Professionals, who provide monthly updates to the Patient Experience Sub Committee. Warrington and Halton Teaching Hospitals NHS Foundation Trust have taken the following actions in response to the personal needs of our patients;

- Communicating effectively with patients is key; Work on the Accessible Information Standard (AIS) has progressed at pace, in the latter part of 2019, and has continued in 2020. This is expected to result in a further improved patient experience.
- Consideration of how discharge planning can be improved, resulting in patients spending less time waiting for tests (and results), medical and therapy reviews.
- An NHSE/I collaborative called 'Personalised Care', has commenced, led by therapy staff. This will help to support effective discharge planning discussions at the point of admission, ensuring that any plans are patient centred.
- The Nutritional Care strategy was launched in Dec 2019 and associated work streams aimed at improving patients' experience of food and drink provision. Improved choice and quality of food is expected to positively influence patient experience in the 2020 national survey results, with nutrition forming part of the Trusts 2021/22 Quality Priorities. Assurances are in place to monitor the results of patient food questionnaires via the Nutritional Steering group and the Patient Experience Sub-committee meetings.

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 will be used to review our services from the patients' perspective and enable us to drive improvements in care.

When patients visit our Accident and Emergency (A&E) Department for treatment, or are admitted to hospital, they are asked to complete a short postcard questionnaire when they are discharged. This details how likely they are to recommend the ward/ A&E department to friends and family if they needed similar care or treatment. The patient's response is anonymous, and they can post the card into the confidential box on their way out of the ward or A&E. The boxes are emptied regularly to process the information and provide reports to the Ward Manager and Matron.

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 through to the board of directors via the Quality Dashboard.

In accordance with National updates to FFT in 2020 the wording of the first question no longer asked about recommending services, instead this was replaced with the following: - 'We would like you to think about your recent experience when completing this form. Overall, how was your experience of our service?' Very good, Good, neither good nor poor, Poor, Very Poor, don't know. This change allows for more emphasis on the importance of using feedback and inclusion.

The Trust has in place an FFT contract in order to improve the process and increase the response rate e.g. text services.

Friends and Family scores 2018/2019 and 2019/20 are as follows:

*Suspended nationally for inpatient wards due to the COVID-19 pandemic, therefore no data is available for this period. A&E continued to collate Friends and Family Data via SMS text messages throughout this period with results detailed in the table below

	Inpatient 2018/19	Inpatient 2019/20	A&E 2018/19	A&E 2019/20	A&E 2020/21
Apr	94%	95%	85%	82%	94%
May	94%	96%	86%	84%	91%
Jun	95%	96%	83%	82%	89%
Jul	95%	94%	84%	82%	89%
Aug	97%	95%	86%	83%	84%
Sept	96%	96%	81%	78%	87%
Oct	94%	95%	81%	78%	81%
Nov	94%	96%	78%	77%	86%
Dec	96%	96%	81%	78%	93%
Jan	94%	95%	76%	81%	93%
Feb	94%	95%	77%	81%	86%
Mar	96%	*	80%	*	79%

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 Duty of Candour

The Trust monitors Duty of Candour at the weekly Serious Incident meeting held by the Clinical Governance team, chaired by the Deputy Director of Governance. Compliance with Duty of Candour is also reviewed at the weekly Executive Meeting of Harm chaired by the Chief Nurse, Deputy Chief Executive and continues to be reported monthly to the Patient Safety & Clinical Effectiveness Sub-Committee.

For each new Serious Incident (SI) investigation, a patient or family liaison officer continues to be appointed to provide support and advice. A one day programme of training for senior clinical staff related to investigation training is in place within the Trust and this includes a bespoke session on the role of the Patient/ Family Liaison Officer role is also available. The Trust is currently implementing 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.

3.10 Staff Survey Indicators

The most updated results from the 2020 NHS Staff Opinion Survey results for the themes of Equality, Diversity and Inclusion and Safety Environment – Bullying and harassment are as follows:

Equality, Diversity and Inclusion

The Trust scored 9.4 for this theme overall which is higher than the comparison with the national Acute Trust average of 9.1

For question 14- 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 90.3% compared to the Acute Trust average of 84.9%. The Trust are above the national average at 90.3% however, the organisation recognises the importance of ensuring equity in relation to progression and promotion and is working in collaboration with the organisation's Staff Networks and the learning and development teams to identify specific learning opportunities and support individuals through their career progression. In addition, the Workforce Race Equality Standard, Workforce Disability Equality Standard and Model action plans all have specific actions targeted towards improving this trend moving forward.

Safe Environment – Bullying and Harassment

The Trust scored 8.4 overall, compared to the Acute Trust average of 8.1.

For question 13b - In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from managers? The Trust scored 11.9% which is a slight increase on the 2019 score but lower than the Acute Trust average of 12.6%The Trust recognises the importance of an inclusive culture and an environment where individuals feel safe within the workplace. To support improving this metric, a targeted action plan has been developed in partnership with Staff Side colleagues and members of our Staff Networks to support the development of a kindness, civility and respect campaign. In

addition, the organisation is working towards becoming an Anti-Racist organisation and has signed up to the Social Partnership Forum's "Call to Action" in relation to bullying and harassment within the NHS. In addition to campaigns and visible commitments, levers such as the grievance policy are being updated and refreshed to contribute to the fostering of positive work environments which will have an impact on this metric.

For question 13c – In the past 12 months how many times have you personally experienced bullying, harassment or abuse at work from other colleagues? The Trust scored 16.0% which is a slight increase on the 2019 score but remains lower than the Acute Trust average of 19.8%.

3.11 Quality Academy

Bringing together our Quality Improvement, Knowledge and Evidence Services and Research, Development and Innovation teams together, the Quality Academy promotes innovation and delivers improvements in line with the Trusts quality priorities.

Objectives

Our Key priorities for the Quality Academy are:

- **To support the delivery the Clinical and Quality Strategies.**
- **Help you to implement innovative ideas.**
- **Training in QI Methodology.**
- **Ensuring QI work is linked in with our quality priorities for the service/Trust to stop duplication and silo-working.**
- **Encourage innovation and increase R&D profile within and outside the Trust – maximising opportunities for patients to take part in research.**
- **Support to move toward best practice – benchmarking ourselves against best in class – therefore using knowledge management.**
- **Become a beacon of exemplary practice on research.**

Engagement

Key to ensuring 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 our patients, the public, our staff and groups such as Governors, HealthWatch and Health Scrutiny Committees.

The Quality Academy work being undertaken with the Patient Experience and patient involvement agenda to ensure that the patient voice is integral to Quality Improvement.

The Quality Academy also works with Workforce & Organisational Development, to ensure that staff engage in the agenda and are empowered and supported to make improvements in their work.

Quality Academy Summit

Each year we hold our annual Quality Academy Summit. The summit presents the latest innovation, best practice, improvement and research. The teams in the academy work together with our internal and external partners to deliver the latest knowledge in innovation and improvement in healthcare. Unfortunately, last year's event was postponed due to Covid but will return in Autumn 2021.

Each summit focuses on a select number of 'themes. Previous themes have included frailty, diabetes and virtual clinics. The event is a unique opportunity to discover the art of the possible, bringing teams together to deliver better outcomes for our patients as well as raising the profile of the Quality Academy and the services available.

3.12 Quality Improvement

The Quality Improvement Team has two main areas of focus; the leading of a number of Quality Improvement projects Trustwide and undertaking a QI capability building programme of work, increasing colleague's knowledge of the theory. This means that colleagues are confident and enthused about approaching opportunities in their work areas and confident in implementing improvements, using our main QI method for implementing change at WHH, The Model for Improvement.

Quality Improvement Projects overview

Falls Collaborative

The Falls Collaborative was suspended in March 2020 due to the COVID-19 pandemic. At the time of suspension, there had been a 9% reduction in Falls on innovation wards since the collaborative started in August 2018. This was relaunched in April 2021.

At the time of writing the business case to support the Quality Academy in August 2020, the collaborative outcomes demonstrated in 2019/20 a financial cost of harm reduction saving of £300k, a 44% reduction in serious incidents and a reduction in severity of harm. The savings are based on the national average cost per fall by severity and age (source, NHS Improvement). These outcomes collectively contributed to improving health outcomes for patients, reducing length of stay, supporting operational capability and reducing the financial cost of falls.

Pressure Ulcer Collaborative

The Pressure Ulcer Collaborative was suspended in March 2020 due to the COVID-19 pandemic. This was relaunched in April 2021.The expert faculty has developed a Pressure Ulcer Change Package for Trustwide implementation.

Quality Improvement Projects (QIPs)

The Quality Improvement Register was established in 2019 to capture improvement projects that are being undertaken across the Trust and enable the QI Team to allocate the appropriate level of support to individuals/teams undertaking improvement work. 44 Quality Improvement Projects were registered in 2020/21, of which 33 in progress, 9 completed.

Quality Improvement Capability Building Programme

A new WHH Quality Improvement Education Framework has been developed to ensure the Trust has a structured and strategic approach to building QI knowledge and capability within our workforce.

During the COVID pandemic, much of the QI capability building programme has been paused. The QI Team have developed Foundation and Practitioner-level training packages and have worked alongside AQUA to devise a structured plan to support and drive learning across the organisation. This has been restarted.

Number of staff completing QI Training to date

Level	Number of Staff
QI Induction	2629
QI Foundation	92

Research & Development

During the Covid-19 pandemic, the Quality Academy Research and Development team have undertaken urgent public health research, including the RECOVERY clinical trial and SIREN. The Trust have opened the Halton Clinical Research Unit undertaken its first Covid-19 trial (Valneva). The unit is dedicated to delivering clinical research to the Cheshire and Merseyside population. This has created opportunities for principal investigators, specialities and clinical support services to be involved in research; raised the research and development profile internally and externally to the Trust; expanded the research portfolio and commercial research. All these factors will continue to contribute to increasing the number of patients that take part in research as part of our key priority objectives.

3.13 Local Quality Initiatives

Improving quality provides an opportunity to deliver better outcomes. There are many examples at Warrington and Halton Teaching Hospitals NHS Foundation Trust that show that even relatively small-scale quality improvement initiatives can lead to significant benefits for patients and staff. The section below details some of the positive work that we have achieved in 2020/2021.

Nursing Times Award 2020

Our Ward team on A7 and the Acute Care Team were shortlisted for a Nursing Times Awards ‘2020 Team of the Year’ for their collaboration during the Covid-19 pandemic.

Health Service Journal Patient Safety Awards

Our Acute Care Team, Acute Pain Team, Respiratory Physiotherapists and Urgent and Emergency Care Team were finalists for the Health Service Journal Awards for the Urgent and Trauma Care Initiative which involved the ‘Introduction of Thoracic Injury Pathway’.

Award winning practice during the pandemic

The ‘Black Box’ is a simple medical device that was transformed into a life-saving therapy for some of the most seriously ill patients with Covid-19 in the spring of 2020. It is an innovative idea which has helped to save the lives of coronavirus patients. Our team were aware of the expected national shortage of ventilators. As a team of doctors, nurses and allied health professionals across the Trust, the team modified simple continuous positive airway pressure black boxes, which are regularly used as therapy for significant breathing problems and low oxygen, as well as to treat patients with chronic sleep apnoea. The

result brought almost instant relief to some patients admitted with extreme breathing difficulties as a result of Covid-19 infection. This also featured on SKY news and gained international interest.

The Trust were delighted to win the Innovating in Adversity category at the London Business School Innovation Awards the team's Black Box idea. The Trust has also been shortlisted for 'Pilot Project of the Year' at the HSJ Value Awards 2021.

Supporting well-being during the pandemic

Alongside a regionally recognised 'wellbeing package', the Trust introduced the 'Borrow Box' App, which offers all of our staff with access to 220+ online audio books and 80+ e-books handpicked to support staff mental health and wellbeing (with no infection risk). It also includes 2 collections of titles written by LGBTQ authors and BAME authors.

Innovative practice during Covid-19

During the Covid-19 pandemic, the Trust's staff have demonstrated their responsiveness whilst being innovative to help support changes at pace in a safe and effective manner. Below are some examples of this from 2020/2021:

- In order to facilitate professional to professional discussions whilst minimising movement of staff between the respiratory and non-respiratory areas, a system of i-pads was set up, one for each area with a unique login using secure NHS email addresses for each. This enabled the medical and nursing coordinators to discuss patients, treatment and plans with each area remotely and safely, whilst also sharing test results for urgent review. These i-Pads were also used for sharing the weekly TED talk (Ten minutes Emergency Department Education) with colleagues in each area, to keep everyone updated with the Evidence Based Medicine approach to COVID and Emergency Medicine.
- In March 2020, 8 Consultants representing each key area formed a COVID Consultant group responsible for collating pathways, processes, and scientific information from the wider knowledge base in the international field, critiquing the Evidence Based Medicine and implementing changes to benefit patients. These Consultants met once per day remotely to discuss urgent changes and were responsible for updating the Trust's standard operating procedures in relation to Covid-19 to ensure they reflected evidence-based practice that was evolving at pace.
- The Trust Resuscitation Lead and Resuscitation Group created a standard operating procedure for the management of patients in cardiac arrest during the Covid-19 pandemic. This involved working with the Procurement Department, Infection Prevention and Control and microbiology team to ensure that each clinical area had access to 5 or more full sets of level 3 personal protective equipment in the event of a patient sustaining a cardiac arrest, as well as delivering face to face sessions in each clinical area for the staff on the correct doffing and donning techniques in the event of a patient sustaining a cardiac arrest.
- The Trust Resuscitation Lead facilitated the purchasing of two external compression cardio-pulmonary resuscitation devices (LUCAS 3) with a spare for use outside the Emergency Department. These were placed both in the respiratory and non-respiratory areas, with the Resus Team giving face to face training to staff within the ED and critical care areas. This process was designed to minimise the amount of physical contact staff had with patients undergoing aerosol generating procedures during a cardiac arrest.

- To support virtual induction and assist multiple learners in the perioperative area, the Theatre Team have developed a Theatre Induction video for new starters in the perioperative environment. This helps to ensure that all staff and students are aware of safety standards in theatre.
- To support patients with Covid-19 being able to return home safely as promptly as possible, the Trust developed a Covid-19 Virtual ward.
- The Trust were delighted to develop a new partnership with Cheshire Fire and Rescue Service. The new innovative partnership enables the Cheshire Fire and Rescue Service to offer a Covid-19 self-swab at home for patients ahead of planned surgery. Patients who were required to self-isolate pre-surgery have benefitted from this service without having to leave their homes. Over 300 patients have benefitted from this service.

New technology in Ophthalmology

The Ophthalmic team at Warrington was delighted to introduce a new diagnostic test which has revolutionised the way patients with serious eye conditions, including diabetic retinopathy are managed. The Trust was the first in the country to purchase this state-of-the-art diagnostic machine, worth over £200,000. The machine has primarily been used to monitor patients with diabetic eye disease, but there are many other ophthalmic conditions it will be used to detect.

Diabetic retinopathy - a complication of diabetes where blood vessels in the eye are damaged - does not tend to cause any symptoms in the early stages, but without prompt treatment can cause permanent blindness. Screening can detect problems before it affects vision, and OPTOS allows this scan to be undertaken quickly and easily, and with minimal time spent in hospital – something essential during COVID and one of the driving forces behind the Trust purchasing the machine.

Halton Clinical Research Unit

In 2020/2021 the Trust were delighted to open the Halton Clinical Research Unit (HCRU), within the Nightingale Building on the Halton site at Runcorn, which will provide opportunities for people in Halton, Warrington, Cheshire and Merseyside to participate in clinical trials and research close to home.

The Trust has been working with the National Institute for Health Research (NIHR), Clinical Research Network North West and Liverpool University Hospitals NHS Foundation Trust (LUHFT) to further develop its research and investigation capability. In 2020/2021 we were delighted to have commenced the first clinical trial, a COVID vaccine trial on Ward B1.

The unit was officially opened on Thursday 4th March 2021 by the Trust's Chairman along with partners. HCRU will provide flexible accommodation and staff to support different types of clinical research and trials.

This investment in the Halton Hospital site is a further demonstration the Trust's commitment to the further development of its research and investigation capacity, supported by the Quality Academy's Research and Development Team. It provides an exciting opportunity for local people and for WHH staff and is pivotal to supporting continual improvement of services provided by the Trust.

Spotlight on Safeguarding

In response to the nationally recognised unknown impact to safeguarding during the pandemic, the Trust carried out focused safeguarding training during August 2020 for all staff including staff from external

organisations. The Trust's Safeguarding Team ran a programme of live learning sessions using MS Teams Live. The Trust's daily Hot Topic in the Safety Huddle reflected a focus on safeguarding. The objective was to raise further awareness among all staff of all elements of safeguarding, reminding them of their own responsibilities and facilitating further learning for front line staff across all staff groups. The event was welcomed by partner agencies in Warrington and Halton boroughs and at a national level with NHS England's Safeguarding team being involved.

The Nest

On 1st December 2020 following a £1.5m investment, The Nest, a midwifery led unit, was opened at WHH. The Nest is the latest addition to the birth options available to the local women of the Warrington and Halton area, as well as across the North West. The Nest offers four en-suite birth rooms, each with its own birthing pool. The state-of-the-art rooms have been designed to promote active, upright labours in a calm and relaxed environment.

Nursing Times Workforce Summit Award

In 2020 the Trust won a Nursing Times Workforce Summit Award for 'Best Recruitment Experience' for our responsive staffing recruitment experience to support rapid deployment during the COVID-19 pandemic.

In response to the nationally recognised staffing challenges in the Covid-19 pandemic, the Trust set up a responsive staffing recruitment process, enabling staff to be ready for deployment to the clinical frontline within 48 hours. The initiative was developed in collaboration with NHS Professionals. The Trust developed the new initiative within ten days, mobilised the service, accompanied it with a multi-channel marketing campaign and a local call to arms asking student nurses or returners to support the hospitals.

The campaign attracted 98 new qualified nurses, 38 new HCAs, 133 student nurses resulting in over 4,000 hours worked by rapid response applicants within general, Emergency Department, and theatre settings.

3.15 Performance against key national priorities

*Performance has been impacted by the ongoing COVID Pandemic. Performance against the relevant indicators and performance thresholds.

National Targets and Minimum Standards	Indicator	Target 2020/21	2020/21	2019/20
Infection Control	Number of clostridium difficile cases due to lapses in care	<= 27	0	14
	Number of MRSA blood stream infection cases	0	1	2
Cancer: 31 day wait from diagnosis to treatment	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	95.60%	98.57%
Cancer: 31 day wait for second or susequent treatment	Anti cancer drugs	98%	100.00%	100.00%
	Surgery	94%	100.00%	100.00%
Cancer: 62 day wait for first treatment	From urgent GP referral (Reallocation position)	85%	72.83%	85.45%
	From the consultant screening service	90%	91.94%	95.33%
Cancer: 2 week wait from referral to date first seen	Urgent GP referral suspected cancer referrals	93%	88.56%	94.26%
	Symptomatic breast patients (cancer not initially suspected)	93%	79.80%	94.46%
Referral to Treatment within 18 weeks	Admitted patients with a clock stop		58.35%	68.73%
	Non-admitted patients with a clock stop		81.47%	90.07%
	Patients on an Incomplete pathway End of March position	92%	70.14%	92.00%
Access to A&E	Patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	85.86%	83.00%
Access for patients with a learning disability	The Trust provides self-certification that it meets the requirements to provide access to healthcare for patients with a learning disability	N/A	YES	YES
Cancelled operations on the day for a non-clinical reason	Number of Cancellations not offered a date for readmission within 28 days	0	54	12
	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	<= 2%	0.42%	0.49%
	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not readmitted within 28 days		54.21%	11.72%

3.16 Quality Report request for External Assurance

Warrington and Halton NHS Foundation Trust has requested the Trust auditors Grant Thornton UK LLP to undertake substantive sample testing of two mandated indicators and one local indicator (as selected by the governors) included in the quality report as follows;

Percentage of patients with a maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Due to the COVID-19 global pandemic work on the auditing of the mandated and local indicators has been postponed for this financial year.

Annex 1: Quality Report Statements

Statements from the following stakeholders are presented within this document unedited by the Trust and are produced verbatim.

Statement from Warrington and Halton Clinical Commissioning Groups

6th June 2021

Dear Simon,

Re: Quality Accounts 2020 - 2021

I am writing on behalf of partners to express our thanks for the submission of Warrington and Halton Hospitals NHS Foundation Trust Quality Report for 2020 – 2021 and this letter provides the response from both NHS Halton and NHS Warrington Clinical Commissioning Groups.

NHS Halton and NHS Warrington CCGs understand the pressures and challenges for the Trust and the local health economy in the last year and recognise during the Global Covid pandemic, that these challenges were beyond anything the NHS has experienced before.

NHS Halton & NHS Warrington CCGs noted the Priorities and progress made in 2020 – 2021:

Patient Safety

• A 5% reduction in gram Negative Bloodstream Infections (GNBSI)

• A 10% reduction in overall numbers of inpatient serious harm falls

• Recording of NEWS2 score, escalation time and response time for unplanned critical admissions

Clinical Effectiveness

• Implementation of Medical Examiners role into the Trust

• Using the best available, current, valid and reliable evidence from Getting it Right the First Time (GIRFT) and National Institute of Clinical Excellence (NICE) to demonstrate effective delivery of healthcare is delivered.

• Strengthening the governance in clinical business units and application across all areas.

Patient and Staff Experience

• Implementation of the End of Life serious illness programme

• Development and implementation of the Trusts Learning Disability Strategy

• Reducing deconditioning in older people with implementation of End PJ Paralysis

NHS Halton & NHS Warrington CCGs noted the Trusts Improvement Priorities for 2021 - 2022:

• **Priority 1 – Patient Safety**

o DNACPR- Improve communication with family/patients with effective communication, documented discussion and inclusive decision making.

o COVID Recovery- robust waiting list management, with clear clinical oversight to avoid and recognise potential patient harm.

o A reduction in Gram Negative Bloodstream Infections (GNBSI) – ensuring that there is a 5% reduction in Bloodstreams infection.

• **Priority 2 – Clinical Effectiveness**

• Medical Examiner- embed the service across the acute setting and act as the pilot site for community implementation.

• Evidence-based Interventions- Ensure effective decisions about health care are based on the best available, current, valid and reliable evidence.

• CBU Governance- to be strengthened ensuring consistency across the organisation.

• Priority 3 – Patient Experience

o End of Life – Serious Illness Programme; Better Communication and Better Care for those sadly reaching the end of life.

o Learning Disabilities and Mental Health Strategies – Trustwide implementation of the Trust Learning Disability Strategy.

o Improve patient experience by enhancing the standard and timely delivery of nutrition.

NHS Halton & Warrington CCGs recognise the challenges for providers in the coming year as we recover from the Covid pandemic and we look forward to working with the Trust during 2021 – 2022 to deliver continued improvement in service quality, safety and patient experience and also on strengthening integrated partnership working to deliver the greatest and fastest possible improvement in people's health and wellbeing by creating a strong, safe and sustainable health and care system that is fit for the future.

NHS Halton & Warrington CCGs would like to take this opportunity to say Thank You to the trust and your staff for their courageous and caring commitment to the ensuring the people of Halton and Warrington receive high quality, safe and effective care and for your on-going commitment locally to system partnership working.

Yours sincerely,

Michelle Creed

Chief Nurse

Statement from the Trust's Council of Governors

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2020/2021.

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

As Governors one of our prime roles, is to focus on quality. As part of the Council's governance structure, it meets regularly at its Governor Quality in Care Group. At the Governor Quality in Care Group, the Governors receive the latest performance information and have the chance to analyse it and raise questions. All Governors receive the Trust's dashboard monthly and can table queries to the Council of Governors (CoG). The Governors have an observer at the Trusts Quality committee who reports to the CoG on the effectiveness of the Non-Executive Director in the role of Chair of the Trusts Quality committee. All these activities have continued in a virtual format thereout the last year.

The formal public governor's council meeting programme is a small part of the governors' work in the Trust. The Governors have several committees which they lead on, which allows them to bring information and views to the main council meeting. Other agenda items include updates from those committees and other topics of interest.

The Governors strongly support the emphasis on patient safety, patient experience and clinical effectiveness documented throughout the Quality Report. Patients, their relatives, carers, and the hospital's key stakeholders have all identified these as three areas of paramount importance.

For the coming year, the Governors agree with the priorities established. The Patient Safety Priority relating to A 5% reduction in Gram Negative Bloodstream Infections (GNBSI), COVID Recovery, waiting list management, appropriate clinical review, and Improvement in the communication processes for DNACPR. The Patient Experience Priorities, Implementation of the End-of-Life Serious Illness Programme., Development and implementation of the Trust Learning Disability and Mental Health Strategies and Nutrition – To ensure that Patients have access to a choice of food and nutrition. Finally, Governors see the Clinical Effectiveness Priorities regarding, CBU Governance to be strengthened ensuring consistently across the organisation, ensure effective decisions about health care are based on the best available, current, valid and reliable evidence, and Embedding the Medical Examiner role across the Trust and Community Services as key areas for delivery of a better all-round patient path through the hospital.

The Governors are happy that the 2019/20 Quality Report provides data that is more meaningful, understandable, and clearer to all, the report shows indicating trends, and comparisons with the previous year statistics. For the coming year, the Governors will review the Quality Report quarterly at our Quality in Care Group thus being up to date throughout the year.

Governors find the format and section headings helpful. The Quality Report contains considerable detail commensurate with the complex and diverse range of services provided by an Acute Hospital Trust. The Governors believe the Quality Report to be accurate. The graphs and accompanying explanations help the public and members to understand clearly the progress made in many areas of patient safety and patient care.

Governors encourage all Trust members and others who are interested in our hospitals and their performance to read the Quality Report.

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

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 boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards 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 2019/20 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2019 to date of signing this statement
  - Papers relating to Quality reported to the Board over the period April 2019 to date of signing this statement
  - Feedback from the Commissioners, Warrington Clinical Commissioning Group and Halton Clinical Commissioning Group - Awaited
  - Feedback from Governors dated 26 May 2021
  - Feedback from local Healthwatch organisations (Healthwatch Halton and Healthwatch Warrington – not mandated this year
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 4th May 2021 approved at Quality Assurance Committee.
  - The 2019 national inpatient survey under embargo until June 2021
  - The 2019 national staff survey published – under embargo until June 2021
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 30th April 2020
  - CQC inspection report dated 24 July 2019

- 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 NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) 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

Xxx Date... Steve McGuirk **Chairman**

xxx **Date**... Simon Constable **Chief Executive**

[NB: sign and date in any colour ink except black]

Independent Auditor's Assurance Report to the Council of Governors of Warrington and Halton Teaching Hospitals NHS Foundation Trust on the Annual Quality Report.

Due to the COVID-19 global pandemic there will be no Independent Auditor's Assurance Report for this financial year.

Appendix – Glossary

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?"
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
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.
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

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