Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Account 2023-24

Contents

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our Mission

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

Our Vision

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

Our Aims

QUALITY

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

PEOPLE

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

SUSTAINABILITY

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

Our Values

- Working Together
- Excellence
- Inclusive
- Kind
- Embracing Change

Our Strategic Aim of Quality

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

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

Part 1

A Statement on Quality from the Chief Executive

and

Introduction from the Chief Nurse & Deputy Chief Executive and Executive Medical Director

1.0 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, from all of the services that we deliver.

I am pleased to present to you Warrington and Halton Teaching Hospitals NHS Foundation Trust's Quality Account. The Quality Account is an annual report which reviews our performance and progress against the quality of healthcare services that we provide, whilst also acknowledging our commitment to further improvement in the coming year 2024-2025.

The Quality Account provides the opportunity to reflect upon achievements, improvements and opportunities for learning, ensuring that patients and families receive the highest quality standard of care when they need it most. The Quality Account provides a progress report across a number of domains including the quality priorities that we focused upon in 2023-24. I am delighted to share the news that the Care Quality Commission continues to rate our Maternity Services as 'Good', following an inspection in September 2023. This is an excellent result for the whole Maternity Team and the Trust, against a backdrop of intense scrutiny on Maternity Services across the country through the National Maternity Inspection Programme which involves an announced inspection of Maternity Services at each Trust.

Progress described within this document is based on data and evidence collected locally and nationally, much of which is presented as part of our performance framework each month in our Quality Assurance Committee, Council of Governors Meetings and public Board of Directors Meetings. We come to the end of 2023/24 not complacent, but with the immense pride in knowing we have performed well as an organisation against many of our key quality targets and quality indicators, details of the performance against these quality priorities are referenced at Part 2.

In Part 3, of this report we report on the performance of other relevant performance indicators and thresholds. We also set out the quality priorities agreed for 2024-25 which have been chosen based upon national and local drivers, our internal governance intelligence and following wide consultation and stakeholder engagement with patients, families, staff, Warrington Disability Partnership and the Integrated Care Board. Information was also gathered to inform the Quality Account from the Patient Equality, Diversity and Inclusion Sub Committee, the Patient Experience Sub Committee and Experts by Experience. Comments received from stakeholders on the content of the Quality Account are included verbatim in full in Annex 1 of this report. Warrington and Halton Teaching Hospitals, NHS Foundation Trust welcomes and encourages the involvement of all stakeholders to ensure that appropriate focus is provided in improving quality for the population that we serve. Similar to 2023-24 our quality priorities identified for 2024-25 will be delivered in accordance with our three domains of quality outlined below:

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

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

- **Priority 3 - Patient Experience:** We will place the quality of patient experience at the heart of all we do, where “seeing the person in the patient” is the norm.

I am pleased to present this year’s Quality Account outlining the embedded governance processes that have allowed myself and the Trust Board to authorise this document as a true and actual account of quality at Warrington and Halton Teaching Hospitals NHS Foundation Trust. I am proud of what we have achieved as a Trust and wider health system in 2023-24. Moving forward to 2024-25 our 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 continually enhancing patient experience. I look forward to continuing to work collaboratively as a system to further enhance the standard and quality of care delivered in 2024/2025.

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

Professor Simon Constable, FRCP,
Chief Executive

Date: 17 June 2024

1.1 Introduction from Kimberley Salmon-Jamieson, Chief Nurse and Deputy Chief Executive and Paul Fitzsimmons, Executive Medical Director

At Warrington and Halton Teaching Hospitals NHS Foundation Trust, we are committed to building a culture of continuous quality improvement, ensuring that the voice of staff and patients is heard. We have launched the 'Five essentials of continuous quality improvement', providing a framework and foundation to drive improvement and successfully implement sustainable change. This focused approach alongside other functions, including the Patient Safety Incident Response Framework (PSIRF) and our cultural programme, will support us to further harness a patient safety and learning culture.

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

In 2019, the Trust was assessed as 'Good' by the Care Quality Commission (CQC). We are delighted to share the news that the CQC continues to rate our Maternity Services as 'Good', following an inspection in September 2023 which was part of the National Maternity Inspection Programme. The report, published on 17 January 2024, is a very positive account across both the safe and well-led domains, which were each individually rated 'Good'. The Trust received no 'must do' actions, with inspectors reporting five 'should do' actions to improve services. These recommendations related to training, further integration of electronic records and refining our approach to policies and procedures.

We are so very proud of all of the hard work undertaken not only within Maternity Services but across the wider organisation, recognising the challenges that all healthcare providers continue to face. We are committed to continue to lead the Trust with vision and clarity towards our ambition to be rated as 'outstanding' for our patients and their families. The dedication of all staff has led to tangible improvements across the quality agenda during 2023-24 and this commitment is set to continue in the forthcoming financial year.

Kimberley Salmon-Jamieson
Executive Chief Nurse & Deputy Chief Executive

Paul Fitzsimmons
Executive Medical Director

Ali Kennah
Chief Nurse

Following Kimberley Salmon-Jamieson successful appointment to another Trust Ali Kennah takes up the role as Chief Nurse From 1 April 2024.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

WHAT IS A QUALITY ACCOUNT?

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

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

This section details:

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

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

Comparative performance benchmarked data.

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

Organisational Structure - How we will Monitor, Measure and Report on-going progress to achieve our priorities for quality improvement.

The Trust's organisational structure allows Warrington and Halton Teachings Hospitals NHS Foundation Trust to be responsive to challenges, through effective clinical engagement with strong and resilient leadership at all levels to deliver the best outcomes for patients. This is achieved through a variety of methods including continuous quality improvement, transformation and research and innovation. The structure was developed collaboratively with stakeholders to deliver care and services utilising a 'Care Group' model which consists of various clinical specialities within a Clinical Business Unit (CBU) structure. There are three Care Group structures at Warrington and Halton Teachings Hospitals NHS Foundation Trust; Planned Care, Unplanned Care and Clinical Support Services all of which work within a

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

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

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

2.1 Looking Back - Performance against Quality Priorities for 2023-24.

The following Quality Priorities were identified and agreed for implementation in 2023-24. These are referenced in accordance with the three domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience.

Throughout the year the progress on each Quality Priority for 2023-24 is reported and monitored on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee, Quality Assurance Committee. Council of Governors, Trust Board of Directors, and the Integrated Care Board.

Quality Priority Proposal (2023/24)

Patient Safety –
We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority.

Improve recognition and response to deteriorating patients

1. Ensure that clinical deterioration is recognised and escalated in accordance with NEWS2 parameters.
2. Evidenced by a 20% improvement in response to patients who trigger a clinical review on NEWS2.
3. Evidenced through audit of response to escalation times.

Reduce the number of category 2 hospital acquired pressure ulcers by 20%, with zero tolerance of category 3 and 4 pressure ulcers (aligned to 23/24 CQUIN)

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

Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework

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

Quality Priority Proposal (2023/24)

Clinical Effectiveness –
Ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients.

Improve a culture of quality, safety and learning through the consistent application of LocSSIPs, achieving >90% compliance in documentation and observational audits.

1. Implementation and audit of LocSSIPs safety standards, with focus on non-theatre areas.
2. Audit of WHO checklist effectiveness with evidence of effective operative and a focus upon theatre culture.
3. Systemisation of safety improvement, evidenced through robust system controls and incident response processes.

Improve Clinical Pathway Optimisation through the 'Getting it Right First Time' (GIRFT) programme.

1. Increase the percentage of patients that receive a diagnostic test across all reportable diagnostic services within 6 weeks to 95%.
2. Improved access to Elective Care through reduced waiting times and improve theatre productivity to 85%.
3. Improve ED waiting times so that no less than 76% of patients are seen within 4 hours.

Improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework)

1. Increase QI capability and capacity by 10% (400) for QI Foundation and 2.5% (100) for QI Practitioner programmes.
2. Achieve 80% (9.6/12) Quality Improvement assessment score in line with CQC requirements.
3. Evidence learning and improvement through Quality Improvement Projects and assurance of actions.

Quality Priority Proposal (2023/24)

Patient Experience –
By focusing on patient experience we want to plan the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

Improve patient experience for those with mental health attendance.

1. Training package to be developed specific to the care of mental health patients in an acute trust with evidence of evaluation.
2. All staff in the Emergency Department to be compliant with the training package and trajectories in place for compliance across all wards.
3. Ensure consistency in the assessment of patients with mental health needs, evidenced through the 1 hour time to review standard where clinically appropriate.

To reduce health inequalities by ensuring that patients and carers have access to appropriate communication methods.

1. Patients with a learning disability are referred and reviewed by the Specialist Nurse/team to ensure that communication needs are met >90%.
2. Embed an alert system for patients, where English is not the first language including British Sign Language.
3. Audit of patients requiring interpretation services as identified through the alert system and actions taken.

Improve patient experience by the pilot of a patient/family 'access line' primarily for out of hours

1. Evidence of Improved patient/ family experience through patient feedback.
2. Feedback from staff to support focused learning and improvement.
3. Results from evaluation to support Trust wide implementation.

Quality Priorities for 2023-24 and the information below contains an update on progress on each of the Quality Priorities under the three domains of quality: patient safety, clinical effectiveness and patient experience.

Patient Safety

Patient Safety - We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority.
1. Improve recognition and response to deteriorating patients. **Leads: Ali Kennah, Deputy Chief Nurse / Debbi Howard, Associate Chief Nurse for Corporate Nursing/Cally Littler, ACPs**
What success will look like
1. Ensure that clinical deterioration is recognised and escalated in accordance with NEWS2 parameters. 2. Evidenced by a 20% improvement in response to patients who trigger a clinical review on NEWS2. 3. Evidenced through audit of response to escalation times.
Q4 progress/ summary
Objectives 1 and 2: **Have all measures / monitoring been achieved.** • Currently being monitored through monthly local audits completed by a Band 6 Nurse or Ward Managers. Training has been provided for auditors. The results of the audits are submitted to a central inbox. The NEWS2 Audit Team have collated the results which are reported on within the NEWS2 Briefing Paper. This paper is presented at the Deteriorating Patient Group monthly. The results are compared alongside the Trust wide audits which were last completed in March 2023, September 2023, and March 2024. The benchmark set at the March 2023 audit was 63%. • The March 2024 Trust wide audit was 78% with a NEWS of 5-6 being escalated correctly. • The Trust wide biannual audit results have been shared with individual ward and departments for local action plans to be completed, these have been overseen by the Lead Nurse and Associate Chief of Nursing for each area. • The results of the local audit data year to date are detailed below:

	Apr	May	Jun	Jul	Aug	Sept
Was the patient escalated correctly? (NEWS 5-6)	**67%**	**72%**	**88%**	**92%**	**80%**	**70%**

	Oct	Nov	Dec	Jan	Mar
Was the patient escalated correctly? (NEWS 5-6)	**89%**	**82%**	**83%**	**77%**	**78%**

Improvement outcomes

NEWS2 role specific training requirements: as of 29 February 2024, training compliance was 94.76%, which is an increase from 72.98% as of 31 March 2023.
The September 2023 Trust wide audit demonstrated an improvement of 7%, showing 70% compliance compared to the 63% benchmark achieved in the March 2023 Trust wide audit.
The March 2024 Trust wide audit was 78% with a NEWS of 5-6 being escalated correctly.
To achieve the 20% improvement, a compliance of at least 75.6% was required. This has been achieved.

Key Learnings

Variation in results between local and Trust wide audits have been observed. This has been addressed through training and by increasing the sample size of local audits from five to 10.
Further communications have been shared with staff to escalate a new and sustained NEWS of 5 or more to the parent medical team/on call out of hours.

As one of the Trust's PSIRF priorities is in relation to the deteriorating patient, any learning from PSIIs in relation to delays in escalation will be triangulated and immediate actions put in place to address.

PSII's have commenced, however there is still work to be done to embed PSIRF methodology and the reporting of lessons learned through Deteriorating Patient Group.

Objective 3:

Have all measures / monitoring been achieved.

In March 2024, 20 patients were identified at the time of review as having a NEWS score 5-6. 4 patients (20%) had evidence of receiving a clinical review within the hour.

Improvement outcomes.

Training and communication have been provided to staff regarding the importance of recording escalation and intervention for those who score a NEWS2 of 5 or more.
Local and Trust Wide action plans are being developed based on results of March 2024 Trust wide audit.

2. Reduce the number of category 2 hospital acquired pressure ulcers by 20%, with zero tolerance of Category 3 and 4 pressure ulcers (aligned to 23/24 CQUIN)

Lead: Tracy Fennell, Deputy Chief Nurse / Debbi Howard, Associate Chief Nurse for Corporate / Heather Aston, Tissue and Viability Specialist Nurse

What success will look like

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

Q4 progress/ summary

Objective 1:

Have all measures / monitoring been achieved.

- Working with Digital Analytics on CQUINN data / reports. The table below provides CQUIN compliance information for quarter's 1-4. To achieve compliance, all elements of the objective need to be achieved including:
  - Pressure Ulcer Risk Assessment (Waterlow) completed within 6 hours of admission.
  - Pressure Ulcer Prevention Care Plan completed within 24 hours of admission (if Waterlow over 10).
  - Pressure Ulcer Risk Assessment (Waterlow) updated every 30 days during admission.

Q1	Q2	Q3	Q4
44.62	**48.21%**	**48.50%**	**47.52%** (at 10.04.24)

- As separate elements, completion of Waterlow within 6 hours is 73.02%.
- The Waterlow compliance which is repeated every 30 days is 77.35%.
- Completion of Care Plan compliance within 24 hours (if Waterlow is over 10) is 25.35%.
- Category two pressure ulcers have increased year to date by 12%.
- In total there were 17 Category 3/unstageable pressure ulcers in 23/24.
- Accurate completion of assessment / care planning documentation is reviewed through After-Action Reviews (AARs). The template for high level briefing papers, which are reported to the Operational Patient Safety Group (OPSG) has been updated to capture key learning and themes from AARs.
- AAR's are reviewed monthly by the Tissue Viability Nurses to identify themes and opportunities for shared learning.
- From January 2024 the Repose Wedge Representative has been providing additional training on wards.
- A fixed term Tissue Viability Nurse funded through Continuing Professional Development funding to support ward based in time education has now ended. Opportunities for support will be explored when 2024/2025 NHSE funding is confirmed.

Improvement outcomes

- An action plan is in place on ward A6 following an increase in pressure ulcers which is overseen by the Associate Chief Nurse for Planned Care.
- A pressure ulcer Task and Finish group has been established by the Deputy Chief Nurse and a work plan developed.

Key Learnings

- Pressure relieving interventions are already initiated within ED (Emergency Department) and AMU (Acute Medical Unit); however, in response to patients staying for longer within the ED Department a change of practice is required relating to assessment and care planning relating to pressure areas. The introduction of the paper-based care plan facilitates this.

- The night mattress store on AMU is now available to AMU staff during day shifts to support timely use of appropriate mattresses (this being from the 19 February 2024)

Objective 2:

Have all measures / monitoring been achieved.

- Incidence of pressure ulcers reported through CBU High Level Briefing Papers (HLBP) to Operational Patient Safety Group (OPSG) and through the monthly IPR Quality Dashboard to Quality Assurance Committee (QAC).
- A pressure ulcer monthly update is prepared by Quality Improvement (QI) for OPSG. This update includes SPC charts for the wards where there is the highest incidence of pressure ulcers in month.

Improvement outcomes

- The template for high level briefing papers to OPSG has been updated so that SPC charts are included within the CBU HLBPs for OPSG.

Objective 3:

Have all measures / monitoring been achieved.

- RCAs have been replaced by After Action Reviews (AAR) under the PSIRF methodology. Copies of the AARs are uploaded to Datix.

Improvement outcomes

- The template for High Level Briefing Papers to OPSG was updated to capture key learning and themes from AARs.
- AAR's are reviewed monthly by the Tissue Viability Nurses to identify themes and opportunities for shared learning.

The data shows that we did not meet this outcome.

	2022/23	2023/24	Mean per month 2022/23	Mean per month 2023/24
Category 2	**114**	**128**	**9.5**	**10.7**
Category 3/4 / unstageable	**11**	**17**		

Note: there could still be changes to final data during April 2024 if there are any Category 2 pressure ulcers from March 2024 which evolve to category 3.

Improvement Action Plan:

An improvement action plan is in place, any updates are reported through OPSG as a standing agenda item.

3. Continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework

Lead: Nicola Edmondson, Associate Director of Governance / Lisa Davies, Patient Safety Manager

What success will look like

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

Q4 progress/ summary

Objective 1:

Have all measures / monitoring been achieved.

- Patient Safety Syllabus Training is available to staff via the ESR platform and is mandated for staff who have been assessed as part of the Training Needs Assessment. Compliance is monitored weekly by senior managers and Executive Leads and is currently 90.9% for level 1, 74.5% for level 2 and 89.4% for senior leaders, targeted messages have been sent to key individuals to increase compliance.
- Human factors training has been delivered to senior leads particularly targeted at those who will undertake learning responses (2 sessions), further sessions have been scoped. Both the Women, Childrens and Theatre leadership are looking to provide bespoke training for their teams.
- We have increased the number of Patient Safety Specialists within the organisation from 2 to 7, these are all currently undertaking the level 3 and 4 Patient Safety Training Syllabus with Loughborough University. Once completed this will be evaluated to understand the opportunities for wider sharing of the learning.
- HSSIB level 2 training is now open again for enrolment and the link has been shared across the trust.
- We have been working in conjunction with AQUA to arrange a two-day PSIRF training event, which will be piloted in March 2024. One of the Patient Safety Partners is attending these sessions.

Improvement outcomes.

- Continue to monitor training figures and support CBU's with new investigation methodologies.

Key Learnings.

- Meetings have been held with each of the CBU's to support the action plan development, with good evidence of improvement noted.
- AQUA two-day PSIRF training event was piloted in March 2024 and is being promoted. Future sessions are being scoped.

Objective 2:

Have all measures / monitoring been achieved.

- PSIRF local priority meetings with all CBU's have been completed to support reviewing of data and analysis alongside local intelligence.
- Local priorities have been discussed and agreed with the Executive Team and the ICB.
- LFPSE and PSIRF went live on 1st September.
- Monitoring of trends and themes in Weekly Safety Summit Meetings. The TOR (Terms of Reference) will be reviewed in Q4.

Improvement outcomes.

- Refreshed Terms of Reference for the Weekly Safety Summit.

Key Learnings.

- LFPSE and PSIRF went live on 1 September 2023, continue to support CBUs.

Objective 3:

Have all measures / monitoring been achieved.

- Initial Safety Reviews are discussed at the weekly Patient Safety Summit Meeting to agree which new investigation methodology is appropriate to identified incidents.
- Plans are being finalised to assist greater impact of learning and sharing.

Improvement outcomes.

- Training continues to be completed for the Governance Managers to support new ways of working and how the CBU can be engaged with support working forward.
- Human factors training has been delivered (2 sessions).
- HSSIB level 2 training is now open again for enrolment and the link has been shared across the trust.
- Plan to measure the impact of learning is being finalised.

Key Learnings.

- Feedback currently from the CBUs has been positive regarding new ways of investigating and engaging with staff and families.
- Progress to alignment of the PSIRF Policy and Plan to further embed governance processes across the organisation continues.
- Warrington and Halton capture learning in different ways and use many differing types of sharing. Mechanisms range from Initial Safety Reviews and other learning responses to debriefs, work system walk throughs etc. Feedback from these is shared via the learning response itself as well as safety briefs, alerts and newsletters, whilst also drawing on wider system learning opportunities to integrate into local improvement events, QI workstreams and audit. Feedback, learning and improvement are crucial to making/building system safety. An action plan will be finalised by the end of Q4, which will assist with learning and sharing, as the PSIRF Policy and Plan are being embedded.

Clinical Effectiveness

Clinical Effectiveness: Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.
1. Improve a culture of quality, safety and learning through the consistent application of LocSSIPs, achieving >90% compliance in documentation and observational audits. **Lead:** Mithun Murthy, Associate Medical Director Clinical Effectiveness / Mark Rigby, Head of Theatres
What success will look like
1. Implementation and audit of LocSSIPs safety standards, with focus on non-theatre areas. 2. Audit of WHO checklist effectiveness with evidence of effective operative and a focus upon theatre culture. 3. Systemisation of safety improvement, evidenced through robust system controls and incident response processes.
Q4 progress/ summary
Objective 1: **Have all measures / monitoring been achieved.** • Non-theatre areas LocSSIPs audits are underway. The intervention radiology audit is due this month (May) and the others are scheduled for later in 2024. **Improvement outcomes.** • Improvement work for Pleural procedure LocSSIPs on ward B18 with progress in adopting new LocSIPPs form. • Assuring ongoing LocSSIP compliance in all other non-theatre areas. The results will be collated and presented at Procedural Safety Steering group (PSSG). **Key Learnings.** • Annual observational audit of all non-Theatre has commenced in January 2024. The results are to be presented and monitored at PSSG. **Objective 2:** **Have all measures / monitoring been achieved.** • Focus on Theatre Safety Culture with review of actions relating to Never Events. Theatre safety day took place on 8 December 2023 and was successful, resulting in several recommendations. An action log is being produced by the Procedural Safety Steering Group (PSSG) and progress will be reported through to PSCESC. **Improvement outcomes.** • The Procedural Safety Programme within Theatres is coordinated and reported on by PSSG. PSSG is a newly established meeting chaired by the Deputy Acute Medical Director and Clinical Effectiveness. • Output of safe surgery audits reviewed and triangulated with other safety data at PSSG.

- PSSG reports to PSCESC (Patient Safety, Clinical Effectiveness Sub-Committee) on a bi-monthly basis, producing an assurance report.
- Refinement of NatSSIPs and other surgical checklist processes.
- NatSSIPs2 implementation to be overseen with a Multi-Disciplinary Team (MDT) approach, widened to include surgical and anaesthetic colleagues.
- Trust participation in AQuA NatSSIPs roll out programme overseen by PSSG reporting to PSCESC.
- Trust to consider undertaking Agency for Healthcare Research and Quality (AHRQ) SOPS hospital survey.
- Planned Care Group have established The Theatre Culture Working Group.
- The Theatre Culture Working Group will plan dedicated planned care audit days to facilitate safety culture development.
- Medical Director to implement programme of leadership development for 2024.

Objective 3:

Have all measures / monitoring been achieved.

- Significant improvement works in systematisation of safety improvement in Theatres through above actions monitored via PSSG.

Improvement outcomes.

- Establishment of Procedural Safety Steering Group (PSSG). The TOR was ratified via PSCESC in January 2024.
- Any LocSSIPs / surgical safety related incident investigations to go through PSIRF methodology with thematic analysis. This is to be included as a running agenda item at PSSG.

Improvement Action Plan.

- A re-audit of pleural procedures including LocSSIPs is underway. The results will be presented at PSSG.
- Repeat observational LocSSIPs audits in all other non-Theatre areas. Individual area leads to undertake with oversight provided by the Deputy Associate Medical Director. These audits have commenced in January 2024.
- The Deputy Associate Medical Director and Clinical Effectiveness to chair Procedural safety steering group (PSSG).
- Safe surgery audit and recommendations from Theatre safety day shared widely with actions monitored through PSSG.

2. Improve Clinical Pathway Optimisation through the 'Getting it Right First Time' (GIRFT) programme.

Lead: Claire Leather, Head of Finance GIRFT (Getting it Right First Time)

What success will look like

1. Increase the percentage of patients that receive a diagnostic test across all reportable diagnostic services within 6 weeks to 95%.
2. Improved access to Elective Care through reduced waiting times and improve theatre productivity to 85%.
3. Improve ED waiting times so that no less than 76% of patients are seen within 4 hours.

Q4 progress/ summary

Objective 1:

- Overall status currently amber. Currently not at 95% across all diagnostics, ongoing plans and workstreams are in place to continue to work towards achieving this target.
- Radiology status is consistently green and is compliant with 95% target.
- Endoscopy, Cystoscopy, Sleep Studies, Echo's status is Amber (approx. 2,500 patients waiting above 6 weeks) and there are action plans in place in order to achieve the targets.
- DMO1 is monitored weekly at PRG and is a Trust performance measure.
- Live data is shared, and plans discussed at PRG which is chaired by the Director of Operations or Chief Operating Officer.
- Trajectories and current performance, including workstreams and any mitigation plans are monitored via the Unplanned Care Transformation Board.

Overview / Key projects.

- Increase the percentage of patients that receive a diagnostic test across all reportable diagnostic services within 6 weeks to 95% including recovery of Cardio-Respiratory and sleep physiology activity.
- Implementation of additional sleep study activity through the Community Diagnostic Centre (CDC).
- Short and long-term planning for delivery of the Echo Service, including contracting for an external provider.
- Short and long-term planning for delivery of the tape analysis.

Progress since last meeting:

- WatchPAT pilot commenced 4 March 2024.

Objective 2:

- Overall status amber. Currently not at 85% utilisation (capped theatre time), plans and workstreams in place to achieve target by March 2025 across all specialties.
- Current metric 67.3% against 85% target (March 2024).

Key projects.

- Delivery of job planned capacity.
- Theatre late starts.
- Theatre utilisation.

Job plans and capacity.

- Job plans and rota analysis via Rotamap now completed for T&O (Trauma & Orthopaedics) and ENT (Ears, Nose and Throat) - No significant issues found in ENT and the delivery of job planned sessions are on target.
- T&O issues remains with 3 session days and staffing availability. This is impacting on delivery of activity and the GIRFT priority – Next steps to look at use of 4-hour sessions and job planning in line with Theatre capacity.

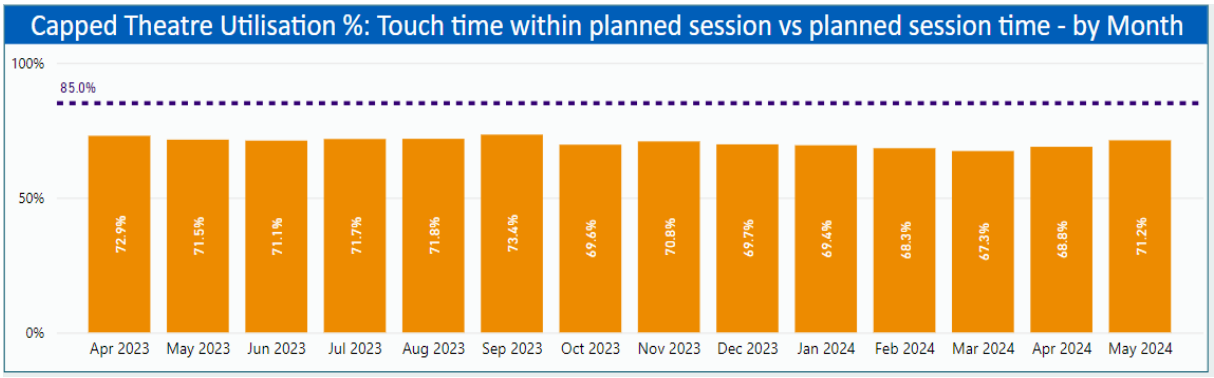
Late starts in Theatres to achieve <50%.

- The current status is green achieving < 50%. As of March 2024, at 36.40% (this has been on target since December 2023).

Site	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Warrington	67.50%	63.50%	63.60%	67.20%	66.70%	67.30%	59.92%	59.40%	42.40%	41.70%	28.30%	40.50%
Halton	51.50%	61.70%	42.50%	50.00%	39.50%	39.50%	50.00%	42.90%	32.30%	30.60%	34.10%	31.30%
CSTM	78.30%	68.40%	68.10%	72.00%	64.30%	50.80%	50.00%	41.60%	25.50%	36.10%	39.20%	33.70%
Overall trust position	68.30%	63.60%	61.40%	59.10%	60.90%	56.90%	55.00%	50.60%	35.40%	38.00%	32.90%	36.40%

Theatre Utilisation to achieve 85%.

- The current status is amber and remains below target.
- March 2024 theatre utilisation was at 67.3%.



Next steps.

- Theatres Productivity and Improvement Group has commenced, this is dedicated to improving all aspects of Theatres relaunched (including support from Productive Partners, GIRFT clinical leads and wider Planned Care Transformation group)
- Reporting into Executive Improvement and Productivity Meeting for oversight, support and escalation of any issues and barriers

Objective 3:

- Overall status is currently amber. Currently not at 76% target, plans and workstreams were in place to aim to achieve target. This will be an ongoing target into 2024/25.

Overview / Key projects.

- **Continuous Flow** - The “continuous flow model” of care sets times for transfer of patients from the Emergency Department to the Admission Unit and from the Admission Unit to wards in advance each day.
- **Type 5** - To record all assessment activity for both SDEC (Same Day Emergency Care) and ED (Emergency Department) Ambulatory as Type 5 in line with the NHS England mandate thus streamlining the reporting through ECDS. This supports national benchmarking of services whilst creating full oversight of occupancy of all areas, at all times, at patient level. This is now live.
- **Emergency Assessment Unit (EAU)** - Majors 2 space to be converted into a pre-admission area for patients with a Decision to Admit (DTA) and who are Clinically Ready to Proceed. Patients will be allocated from this area to available beds based

upon there clinical condition for both Medicine and Surgery this will support continuous flow. This is now open.

- **Streaming** - Review of assessment area pathways was required to ensure that alternative pathways are maximised from initial triage or GP referral to reduce occupancy in ED. This includes a review of; ED Ambulatory, SDEC, GAU, PAU, and FAU. Weekly meetings in place to support progression and the streaming of all patients.
- **Triage** - Review of triage processes and standardisation throughout department. Manchester Triage introduced in line with other acute Trusts across the region. An action plan is in place to support this workstream with weekly meetings in place with key stakeholders.
- **Ambulance Handovers and collaboration with NWAS** - Ongoing QI project working with NWAS to reduce handover delays. Task and finish group established to implement direct referrals to SDEC from NWAS.
- **Relocation of ED Ambulatory to SDEC** - Supporting crowding in ED and increase footfall in SDEC over weekends.

Improvement Action Plan.

- Current RAG status of this priority is amber.
- See key actions, RAG ratings and timescales in each of the sections above.
- Continue with plans and workstreams in place.
- Ongoing monitoring plans and performance through Transformation Meetings, PRG, Executive Team Meetings.
- Escalate any barriers or issues via weekly Executive Meetings.

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

3. Improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework)

Lead: Ernesto Quider, Associate Director of Quality/ Imogen Lyons, Head of Continuous Quality Improvement/Fliss Swift, Head of Compliance

What success will look like

1. Increase QI capability and capacity by 10% (400) for QI Foundation and 2.5% (100) for QI Practitioner Programmes.
2. Achieve 80% (9.6/12) Quality Improvement assessment score in line with CQC requirements.
3. Evidence learning and improvement through Quality Improvement Projects and assurance of actions.

Q4 progress/ summary

Objective 1:

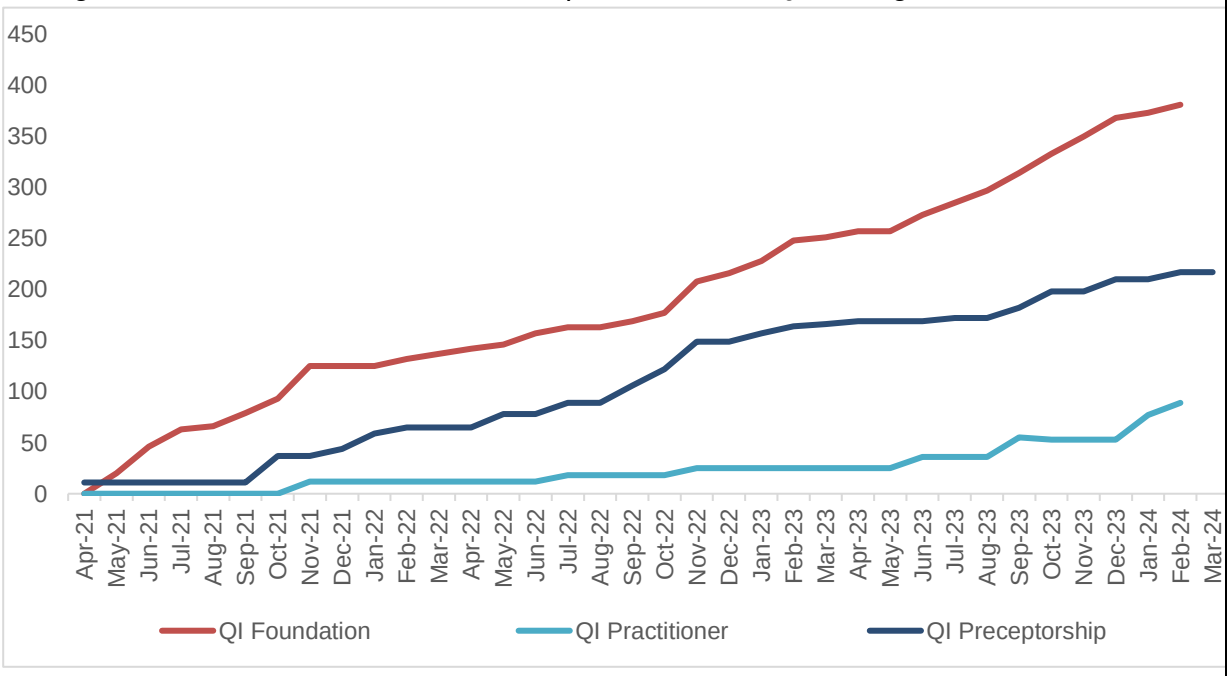
Have all measures / monitoring been achieved?

Figure 1 shows the increase in training delivery to date up until the end of the financial year.

In summary:

- 388 staff had completed Foundation training (Level 2).
- 89 staff have completed or are in the current cohorts of QI Practitioner training (Level 3, including 12 staff that have been offered an additional bespoke cohort).
- 217 staff in the Preceptee Programme have received Introductory training (Level 1)
- The CQI team have delivered 219 hours of coaching in this financial year that supplements and consolidates QI training knowledge and skills.

Figure 1: Number of staff that have completed in house QI training



Despite the best efforts of the CQI team and an increasing demand for training, the training targets will not be met by the end of the financial year. The reasons for the shortfall in training numbers are multifactorial, the top three likely contributors are:

- Reduced capacity/ resource of the central CQI team to plan and deliver additional training.
- Operational pressures- staff drop out or are unable to complete the training.
- Training capacity trajectory did not match demand.

Opportunities for Improvement

There is a CQI Team management system review and development underway to further analyse capacity and demand for training and develop outline plan for the next financial year.

The CQI Team have now established a forward plan for standardising and progressing QI training strategically across the Trust. This was presented at January's Quality Academy

Sub-Committee (QASC) and underwent a period of consultation. There will be an expectation that all staff employed by the Trust will be trained in QI, and this will be targeted to their job roles. The outline proposal is that there will be 6 levels of QI training across the organisation from Level 1 (Introduction) to Level 6 (Expert faculty). Implementation of this plan for the next financial year is in progress.

Objective 2:

Have all measures / monitoring been achieved?

We have completed a collaborative piece of work with the Head of Compliance to develop an evidence base for self-assessment against the Single Assessment Framework CQC criteria required to demonstrate a mature QI approach. This has been linked to the broader mock inspection programme.

To achieve at least an 80% score for the CQC requirements at least 9.6 of the 12 domains would need to evidence demonstrating a mature approach to QI. At the end point assessment during March 2024 in 11 of the domains the criteria have been met, with a plan to provide further evidence once completed in Q1 24/25. This results in a 92% QI maturity score in line with CQC requirements (see separate document 2023-2024 Quality Priorities QI maturity Metrics CQC Analysis and Evidence Database).

It is important to note at the end point assessment that the evidence collected to meet the assessment score are based on interpretation of a subjective descriptor of each domain. There is no robust methodology available to determine where the criteria have been met and further evidence may be required by the CQC if requested. The Head of CQI, Head of Compliance and Associate Director of Quality will be required to review the available evidence to ensure the assessment score is updated as further work is ongoing to build a mature culture of QI across the organisation.

Objective 3:

Summary of progress, position statement at the end of the financial year:

The management of quality improvement projects and systems to disseminate evidence of learning and improvement has undergone a period of evaluation and redevelopment this financial year. The CQI team hold a central record of QIPs (Quality Improvement Projects), however, it is important to note this is not an accurate representation of all WHH QI work as the system relies on staff registering through the central database.

The development of an internal quality management system is a long-term aim and would be required to fully meet the requirements of this objective.

To improve our position and as part of the ongoing work to develop a QI culture, the following summary will demonstrate the progress in this objective and highlight opportunities to further develop our quality management systems into the next financial year:

Previous system areas for improvement:

- Waiting to the project end to collect evidence of learning and no mechanism to standardise sharing of outcomes.
- No system of recording project progress (i.e. at what stage a project was in and identifying barriers to progression).

- No standardised way of reporting to link QIPs to governance systems or key update meetings.

New systems developed this financial year:

- Impact statements added to QIP registration database to collect learning proactively.
- M2O pieces written and shared to highlight improvement work.
- Developed a standard project progress and assessment criteria based on the IHI (Institute for Healthcare Improvement) Standard Assessment Scale to assess the quality of completed projects and will use this to inform further guidance on completing and reporting projects.
- Launch of a quick reference guide, a WHH Essentials of CQI vision and QIP SOP.
- The QIP SOP outlines a more robust system of identifying projects that have not progressed or have been completed and escalation through the governance system.
- QI agenda items on care group/ CBU Governance Meetings following a series of engagement activity.
- Database of QIPs now sent monthly to Governance Mangers to cross reference against governance actions. Further engagement underway to establish and standardise where info will be shared/ reported.
- Development of shared learning forum. The aim of the forum is to provide an opportunity for WHH colleagues, partners and people with lived experience of our services to share and learn from a wide range of quality and safety related initiatives, improvement and innovation projects, patient and staff feedback, to celebrate outstanding practice and learn from excellence.
- Development of the QIPC (Quality Improvement Practitioner Community) to network, share and learn from improvement projects.
- Operational patient safety group reporting redesigned to include SPC charts where appropriate and improve the system to identify and report on related local QI work.

Next steps and opportunities for improvement:

- Develop standardised system for sharing learning from QIPs and recognise success via certification and presentations.
- Further develop clear channels of reporting/ communication through governance systems.
- Continue to develop links with clinical audit and contribute to share-point update to automate some QIP communication functions, freeing up capacity of central team.

Improvement Action Plan:

- CQI team to continue delivery of training, review capacity and demand for training and to implement the forward plan for 24/25 (capability and capacity building plan, presented to QASC and signed off by execs March 2023).
- Annual review of CQC evidence matrix with Head of Compliance/ ADQ/ Head of CQI to refresh and update as required.
- If required by the CQC, ad hoc review of the assessment score and update to be completed by the Head of Compliance/ ADQ/ Head of CQI.
- CQI team to continue work on development of internal QI management system into 24/25 as part of team objectives/ work plan.

Patient Experience

Patient Experience: By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.
1. Improve patient experience for those with mental health attendance. **Leads**: Emma Painter, Associate Chief Nurse for Unplanned Care/Layla Alani, Director of Governance & Quality, Deputy Chief Nurse
What success will look like
1. Training package to be developed specific to the care of mental health patients in an acute trust with evidence of evaluation. 2. All staff in the Emergency Department to be compliant with the training package and trajectories in place for compliance across all wards. 3. Ensure consistency in the assessment of patients with mental health needs, evidenced through the 1-hour time to review standard where clinically appropriate.
Q4 progress/ summary
Objective 1: **Have all measures / monitoring been achieved.** • A Training Needs Analysis has been completed and this has identified that different staff groups have differing training needs. The three main themes for training relates to the: 1) Provision of mental health observations/enhanced care 2) The legal requirements for detaining or caring for someone who is detained under the Mental Health Act 3) Mental Health conditions – the symptoms and treatment pathways • In respect to point 1 - The Trusts Enhanced Care Policy has recently been updated. • Training has been delivered on the provision of enhanced care, including mental health observations to the HCAs who work in the emergency department. • Evaluation of the feedback of this training is underway and it is planned that this training will be rolled out to the nurses and doctors in ED. • This training will then be further evaluated with feedback from the nursing and doctor professional groups, before a planned roll out across other wards and departments. • In respect to point 2 - A Mental Health Act Policy has been written and implemented within the Trust. The Trust solicitors and the Mersey Care Mental Health Law Team have been approached to develop and implement a training package which specifically focuses on the legal requirements of the Mental Health Act. Additionally, a training session has been delivered to Senior Nursing Teams across the organisation to increase their awareness and knowledge of the Mental Health Act. • In respect to point 3 - a training package and dates are being organised for ED staff to attend training dates following a programme of work delivered by Core 24. The delivery of this training will be via two mechanisms – the mental health team will work alongside WHH nursing teams for one hour and then a one-hour drop-in session will follow. This will be delivered every two weeks. After a three-month period, this training package and delivery method will be evaluated and amended based on feedback.

- Awareness raising relating to patients cared for at Arbury Court has been undertaken, to support learning for patients with very complex mental health needs – this has been shared at Medical Cabinet and Nursing and Midwifery Forum.

Improvement outcomes.

- Staff will feel more confident and competent in understanding how to care for patients with a mental health diagnosis both in terms of assessment, treatment and communication.
- Feedback from the HCAs in ED that received the training on enhanced care observations was positive and the team put forward some service improvement and patient experience ideas which are being reviewed by the UEC tri.
- The training for Senior Managers on call has been received positively with staff raising questions supporting further learning. This will be delivered periodically as part of the senior manager on call training.

Key Learnings.

- Trustwide communications have been made to share the Cheshire Police initiative of Right Care Right Person which launched on Monday 8 January 2024.
- The Trusts Missing Person Policy has been updated in conjunction with Cheshire Police and is now live. This will support the changes that will be made to the way in which police will respond to patients who abscond and concerns for welfare.

Objective2:

Have all measures / monitoring been achieved.

- HCAs within the ED have received a training package during Q4, which has been received positively.
- Amendments will be made as required, and a plan will be put in place for roll out across the Nursing and Medical Teams, firstly in ED and then other Trust areas.

Improvement outcomes.

- Improved knowledge and understanding.
- Staff satisfaction and confidence.
- Improved quality assessments.

Objective 3:

Have all measures / monitoring been achieved.

- Mental health Triage Tool has been reviewed and updated to ensure consistency in the initial assessment and triage of patients identified as having a mental health presentation.
- The number of patients in the Emergency Department with a mental health presentation is monitored at every bed meeting, allowing for timely escalation of any concerns or delays.
- Intentional rounding, which happens every 2 hours in the Emergency Department, reviews the risk assessment of those patients who are identified as having a mental health concern. Compliance with intentional rounding is monitored via a weekly audit by the UEC matron.
- Working with Mersey Care on obtaining their performance data to monitor 1 hour assessment standard. This Head of Operations is reviewing the provision of the data.

Improvement outcomes.

- Consistency in documentation and knowledge applied with clear actions and rationale.

Key Learnings.

- Improved knowledge and understanding.
- Staff satisfaction and confidence.
- Improved quality of assessments.

2. To reduce health inequalities by ensuring that patients and carers have access to appropriate communication methods.

Leads: Jen McCartney, Head of Patient Experience and Inclusion / Zetta Edwards, Specialist Safeguarding Nurse

What success will look like

1. Patients with a learning disability are referred and reviewed by the Specialist Nurse/Team to ensure that communication needs are met >90%.
2. Embed an alert system for patients, where English is not the first language including British Sign Language.
3. Audit of patients requiring interpretation services as identified through the alert system and actions taken.

Q4 progress/ summary

Objective 1:

Actions taken to support the objective include:

Database developed to capture data and provide assurance.

ICE notifications received and notification via data warehouse are used to identify both children and adults with a Learning Disability (LD), where communication will be picked up.

Hospital communication booklet is available to support patients with LD and communication difficulties.

Widgit and Widget health are available to support easy read material for communication aids.

Flashcards are available on the learning disability/autism workspace for all Trust staff.

Training sessions to be made available to support how to use the communication aids.

Coordinating a LD awareness day that would look at supporting LD patients and how communication can support them to be involved in their care.

Makaton subscription for signs within the hospital to support patients who have a LD and use this sign language to be more inclusive.

Makaton sign and symbol of the week completed within the week bulletin every Friday.

Makaton training by an External Makaton trainer held on a quarterly basis.

Improvement outcomes

- Raising staff awareness

- Simplifying communication styles.
- Improve communication which will positively impact on patient care.
- Providing accessible facilities.
- Tailored resources.

Key Learnings

- Database and collection process confirm, and data collection commenced 1st October 2023, results are available as needed.
- Training sessions for the usage of the communication booklet, flashcards and widget health on track for June 2024, with communications at present and on workspace.
- Makaton sign and symbol of the week has been removed from the Monday safety brief and is now available in the circulated newsletter the 'the week'. Whilst this information remains available to trust staff – the visual example of the sign has been removed.
- Makaton subscription for 2024 as been agreed and running, further details to support.

Objective 2:
Have all measures / monitoring been achieved.

- The Trust use Lorenzo for recording alerts for patients who require support, this includes languages and British Sign Language. An alert takes the form of a star bust on the patient banner, to show staff accessing records that some form of support is required. The alert is then broken down into categories including but not limited to visual and hearing impairments. The Trust are supported by the contracted Interpretation Services from the Deafness Resource Centre who attend meetings with the Head of Patient Experience and Inclusion. The Deafness Resource Centre are also represented as key members of the monthly Trust Patient Equality Diversity and Inclusion Sub Committee (PEDISC).
- A full rebrand was undertaken and launched by the communications team which also includes accessible information standards, use of clear and easy to understand language, formats of documents and translated documents.
- Work has commenced to develop a visual alert on paper notes and at bedsides that alerts any staff members that the patient requires communication support.

Improvement outcomes

- Regular information is sent out via Trust communication channels promoting d/Deaf training for all staff.
- Regular meetings with signing solutions are held with Patient Experience and Inclusion Team and Deputy Chief Nurse to discuss d/Deaf Action Plan. In addition, mapping d/Deaf Patient Journeys is due to commence in April 24 to understand support in place and improvements required.

Key Learnings

- Further work ongoing to ensure translation/interpretation services are used appropriately. Bringing in health partners to support, presented at monthly Patient Experience meetings.

Objective 3:
Have all measures / monitoring been achieved.

- Currently working with patient safety team to develop a visual alert/prompt to staff for awareness when patients require communication support.

Improvement outcomes

- Contract revisions delayed with procurement, due to procurement staff recruitment.

Key Learnings

- Audits have commenced from April to end of September 2024 to highlight if any improvements are required on alert system.

Improvement Action Plan

- Database and collection process confirm, and data collection commenced 1st October 2023, results are available when needed.
- Training sessions for the usage of the communication booklet, flashcards and widget health on track for June 2024, with communications at present.
- Makaton sign and symbol of the week has been removed from the Monday safety brief and is now available in the circulated newsletter the 'the week'. Whilst this information remains available to trust staff – the visual example of the sign has been removed.
- Makaton subscription for 2024 as been confirmed and working through support of signage within the hospital and for easy read material, target is June 2024.

3. Improve patient experience by the pilot of a patient/family 'access line' primarily for out of hours

Leads: Nicola Edmondson, Associate Director of Governance / Ellis Clarke, Matron

What success will look like

1. Evidence of Improved patient/ family experience through patient feedback.
2. Feedback from staff to support focused learning and improvement.
3. Results from evaluation to support Trust wide implementation.

Q4 progress/ summary

Objective 1:

The access line will now be considered as 'Call 4 Concern' in accordance with the national programme. This will provide:

- Supplementary support in the provision of a telephone line where service users, relatives and their carers can contact a senior member of staff, if they are concerned regarding a patient's clinical condition or notice a change in their clinical condition. They may also call if the Ward Team is not addressing the concern or feel that there are inconsistencies in how care is being given and require an immediate resolution.
- This is not intended to replace local departmental/ward resolution, however, enable the provision of immediate supplementary support.
- The Acute Care Team are responsible for the management of the phone line and are the point of contact.
- Adult Intensive Care (ICU) patients who have stepped down to adult wards were the initial pilot group.
- The pilot commenced on 29 January 2024. No calls were received during this phase of the pilot. 2 further ward areas were therefore added to the pilot in March 2024.

- Information leaflets are being given to patients who are in the pilot areas.
- If a Call 4 Concern is received about a patient, this is documented by the Acute Care Team on the Lorenzo CDC form, viewable through the medical charts option. A reason for referral drop down is used to track the reason for contact. This form captures: Date and time of review, summary of care, resuscitation status, airway, breathing circulation, disability, exposure, fluid balance, investigations, acute kidney injury (AKI) grade, sepsis suspected, plan of care, escalation plan, when discussed with Intensive Care and capacity.
- To date 1 call has been received, regarding a patient in the Emergency Department (ED).
- The project team are preparing for a Trust wide roll out (of adult in patient areas) on June 3, 2024.

Objective 2:

- A Call for Concern Steering Group supported planning of the project, this included representation of experts by experience.
- A communication plan had been enacted for the pilot and this is currently being refreshed ahead of the Trust wide roll out.

Objective 3:

Initial measures have been defined to understand improvements, these include:

- Monitoring for reductions in the number of out of hour queries (PALS) received relating to clinical deterioration (quarterly).
- Monitoring for a reduction in the number of clinical incidents reported relating to clinical deterioration (quarterly).
- Auditing what concerns are raised out of hours, what was the action taken, were they standardised and was the issue resolved.
- Quarterly review of qualitative feedback from questionnaire.
- Work has been undertaken with informatics and has enabled the ability to extract CDC details out of Lorenzo, this will support analysis of data, when there is sufficient data.

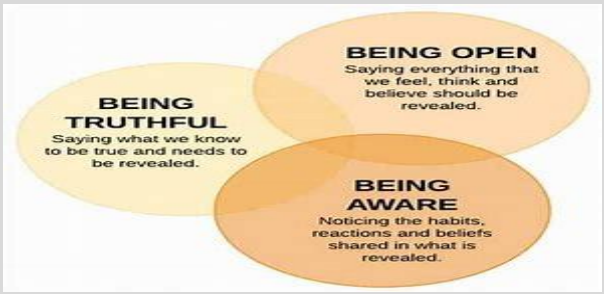
Improvement outcomes.

- Improved accessibility for patient to access senior staff out of hours and resolve concerns.
- Improved patient experience and satisfaction.
- Reduced number of complaints /PALS/ incidents linked to clinical deterioration.

Improvement Action Plan.

- Enact refreshed communication plan for Trust roll out.
- Register an audit to enable evaluation of concerns raised out of hours, action taken and resolutions.
- Further work with Informatics to understand data.
- A record of the number of patients and time taken will continue to be recorded, this will then form the basis of an impact assessment for the Acute Care Team.
- Ongoing evaluations via surveys and quantitative data reviews.
- The Trust have been selected to progress as an early adopter of Martha's Rule.

Further to the agreed quality priorities 2023-24 Warrington and Halton Teaching Hospitals NHS Foundation Trust has also achieved a number of quality measures that evidence improvement across all three domains of quality. These include:

	**Statutory Duty of Candour Requirements** The Trust has consistently achieved 100% compliance in the notification of duty of candour both verbal and written (within 10 working days) following the occurrence of a notifiable patient safety incident.
	**Successful Implementation of Patient Safety Incident Response Framework (PSIRF)** Our implementation of the PSIRF has been successful, making use of new tools and techniques to adopt a system thinking approach to our learning, supported by our Patient Safety Partners and specialists.
	**Patient Experience Network National Awards 2023** **Runner up** - the Family Integrated Care (FICare) model on the Neonatal Unit at Warrington Hospital in the Communicating Effectively with patients and family category. **Runner up** - 'Your Future Your Way' programme in the Strengthening the Foundation category.

	**The Northwest Neonatal ODN (Operational Delivery Network)** awarded the Family Integrated Care (FICare) model on the Neonatal Unit at Warrington Hospital green status in July 2023.
	**RCN North West Award** For Outstanding Contribution to Equality, Diversity, and Inclusion in October 2023 for Your Future Your Way'
	**The Captain Sir Tom Moore Building at** Halton Hospital has been named as a Quality Data Provider after successfully completing a national programme of local data audits run by the National Joint Registry (NJR) in August 2023.
	**Healthcare People Management Association Awards** 'Your Future, Your Way' finalist in the Excellence in Organisational Development category. The 'Wellbeing at Warrington and Halton Hospitals with Rugby League Care project' was a finalist in the Browne Jacobson Award for excellence in employee engagement category. September 2023.

2.2 Our Strategic Aims of Quality 2024-25.

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

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

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

- **Priority 3 - Patient Experience:** We will place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

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

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

With the above measures of success in mind, the infographics below demonstrate our focused commitment to continually improve our services across the three domains of quality in 2024-25.

2.3 Looking Ahead – Our Quality Priorities 2024-25.

This section identifies:

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

Warrington and Halton Teaching Hospitals, NHS Foundation Trust has a duty to fully engage with stakeholders to ensure that priorities are both meaningful and focused, not only utilising internal intelligence but by hearing from a variety of groups that access our services. Feedback has been gathered throughout 2023/24 through engagement and discussion with the following:

- Non-Executive Directors/Executive Team.
- Governors.
- Patients and families.
- Experts by Experience.
- Staff.
- Staff Survey: Link https://cms.nhsstaffsurveys.reports/2023/RWW-benchmark-2023.pdf
- Integrated Care Board (PLACE presentation).
- Warrington Disability Partnership.
- Healthwatch.
- Patient Experience Sub Committee and Experts by Experience.
- Patient Equality, Diversity and Inclusion Sub-Committee.

- Staying Connected Forum –distribution to patients and advocacy groups.
- World Quality Day.

Learning from incidents, complaints, claims and risk has also been utilised to inform the proposed quality priorities 2024/25. The agreed quality priorities are outlined below. Progress will be monitored through quarterly reports submitted to the Patient Safety and Clinical Effectiveness Sub Committee and to the Trusts Quality Assurance Committee, which in turn provides assurance to the Trust Board of Directors.

Our Quality Priorities 2024 - 25

The improvement aims	Description of Quality Priorities	The outcome
Improve patient safety	1. Ensure that all patients within the Emergency Department receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes 2. Reduce elective long waits by having no patients waiting > 6 weeks for a diagnostic test and improve performance 3. Reduce the number of category 2 pressure ulcers by 20% with zero tolerance of category 3 and category 4 pressure ulcers	**Patient safety is enhanced through a learning culture where quality and safety is everyone's top priority**
Improve clinical effectiveness	4. Improve the safety culture in theatres with focus on consistency, psychological safety; and learning, evidenced through 95% compliance with safe surgery standards aiming for no procedural Never Events in theatres 5. Continue the GIRFT programme delivering the Trust's GIRFT objectives in each of the Care Groups to deliver more timely and effective patient care 6. Continue to embed Patient Safety Incident Response Framework by developing organisational culture programme and learning system across the Trust	**Practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients**
Improve patient experience	7. Ensure that there are robust frameworks in place to care for patients with mental health challenges, evidenced through the implementation of a training package for nursing and medical staff and 95% compliance with the completion of Mental Health Act assessment and detention documentation 8. Improve discharge processes to support clinical demand and safe patient care, evidenced through a maximum of 15% bed occupancy in the number of patients with no right to reside, averaged over 12 months 9. Ensure 95% compliance in the completion of assessments relating to nutrition and hydration with assurance of appropriate action undertaken to improve clinical outcomes	**The quality of the patient experience is at the heart of all we do and 'seeing the person in the patient' is the norm**

2.4 Statements of Assurance from the Board

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

2.5 Information on the Review of Services.

During 2023-24, the Warrington and Halton Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 7 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 7 of these relevant health services (contracted services).

The income generated by the Health Services reviewed in 2023-24 represents 100% of the total income generated from the provision of relevant Health Services by the Warrington and Halton Teaching Hospitals NHS Foundation Trust for 2023/24.

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

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

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

The Clinical Audit Department is committed to raising the profile of clinical audit within the Trust recognising the importance of the annual forward audit plan and its contribution to improving patient outcomes and experience. The Trust-wide Forward Audit Plan 2023-24 was implemented at the start of the financial year following approval by the Patient Safety and Clinical Effectiveness Committee and by the Quality Assurance Committee.

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

The Trust is also committed to undertaking local clinical audits many of which focus upon some of the greatest challenges experienced by the population that we serve. The information below provides an overview of all the national clinical audits, confidential enquiries and local clinical audits undertaken during 2023-24.

2.6.1 Participation in Quality Account Clinical Audits 2023-24.

During 2023-24, 48 National Clinical Audits and 4 national confidential enquiries covered relevant health services that Warrington and Halton Teaching Hospitals NHS Foundation Trust provides.

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

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

The table below shows:

1. The national clinical audits and national confidential enquiries that Warrington and Halton Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2023-24.
2. The national clinical audits and national confidential enquiries that Warrington and Halton Teaching Hospitals NHS Foundation Trust participated in during 2023-24.
3. The national clinical audits and national confidential enquires that Warrington and Halton Teaching Hospitals NHS Foundation Trust participated in, for which data collection was completed during 2023-24. These are listed below alongside the number of cases submitted to each audit or enquiry.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
1.	**Adult Respiratory Support Audit**	Yes	No	A local version of this audit is currently open for local data capture purposes. The Trust is currently submitting data this
2.	**BAUS Nephrostomy Audit**	Yes	Yes	3 cases submitted
3.	**Breast and Cosmetic Implant Registry**	Yes	Yes	15 cases submitted, ongoing data submission
4.	**British Hernia Society Registry**	Yes	Yes	Clinicians currently registering with the Registry
5.	**Case Mix Programme (CMP)**	Yes	Yes	683 cases submitted, ongoing data submission
6.	**Child Health Clinical Outcome Review Programme**	Yes	Yes	See table below with National Confidence Enquiry into Patient Outcome and Death Information
7.	**Cleft Registry and Audit Network (CRANE) Database**	N/A		
8.	**Elective Surgery: National PROMs Programme**	Yes	Yes	Latest published data 2020-2021. EuroQol-visual analogue scales (EQ VAS) modelled records. Ongoing data collection: Hip replacement primary 28- Hip replacement revision 1

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				Knee replacement primary 28 Knee replacement revision 1 Total hip replacement 29 Total knee replacement 29
9.	**Emergency Medicine QIPs**			
	a. Care of Older People	Yes	Yes	242 cases submitted – audit runs Oct 2022 - Oct 2023
	b. Mental Health (Self-Harm)	Yes	Yes	0 cases submitted to date – audit runs Oct 2023 - Oct 2024
10	**Epilepsy 12 - National Clinical Audit of Seizures and Epilepsy for Children and Young People**	Yes	Yes	Latest published data 2022 44 cases submitted, ongoing data submission
11	**Falls and Fragility Fracture Audit Programme:**			
	a. Fracture Liaison Service Database (FLS-DB)	N/A		
	b. National Audit of Inpatient Falls (NAIF)	Yes	Yes	8 cases submitted, ongoing data submission
	c. National Hip Fracture Database (NHFD)	Yes	Yes	461 cases submitted, ongoing data submission
12	**Improving Quality in Crohn's and Colitis (IQICC)** *(Note previously named Inflammatory Bowel Disease (IBD) Audit)*	Yes	Yes	492 cases submitted. Registry closed on January 2024.
13	**Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)**	Yes	Yes	17 cases submitted
14	**Maternal, Newborn and Infant Clinical Outcome Review Programme**	Yes	Yes	Multiple studies: Perinatal mortality surveillance report Jan 2021-Dec 2021 2621 cases submitted, ongoing data submission

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
15	**Medical and Surgical Clinical Outcome Review Programme**	Yes	Yes	See table below with National Confidence Enquiry into Patient Outcome and Death Information
16	**Mental Health Clinical Outcome Review Programme**	N/A		
17	**National Adult Diabetes Audit (NDA):**			
	a. National Diabetes Footcare Audit	Yes	Yes	39 cases submitted, ongoing data submission
	b. National Diabetes Inpatient Safety Audit	Yes	Yes	14 cases submitted, ongoing data submission
	c. National Pregnancy in Diabetes Audit	Yes	Yes	8 cases submitted, ongoing data submission
	d. National Diabetes Core Audit	Yes	Yes	2855 cases submitted, ongoing data submission
18	**National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP):**			
	a. Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes	485 cases submitted, ongoing data submission
	b. Pulmonary Rehabilitation	Yes	Yes	106 cases submitted, ongoing data submission
	c. Adult Asthma Secondary Care	Yes	Yes	147 cases submitted, ongoing data submission
	d. Children and Young People's Asthma Secondary Care	Yes	Yes	38 cases submitted, ongoing data submission
19	**National Audit of Cardiac Rehabilitation**	Yes	Yes	837 cases submitted, ongoing data submission
20	**National Audit of Cardiovascular Disease Prevention in Primary Care**	N/A		
21	**National Audit of Care at the End of Life**	Yes	Yes	50 case note reviews, 74 completed Staff Reported Measures and 10 Quality Surveys Responses (patient / carer surveys)
22	**National Audit of Dementia**	Yes	Yes	60 cases submitted, ongoing data submission
23	**National Audit of Pulmonary Hypertension**	N/A		

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
24	**National Bariatric Surgery Registry**	N/A		
25	**National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer**	Yes	Yes	Latest data submitted as an 'indicator' April 2023 to January 2024: Recurrences – 10 Progressions – 2
26	**National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer**	Yes	Yes	Latest data submitted as an 'indicator' April 2023 to January 2024: Primary breast – 233
27	**National Cardiac Audit Programme (NCAA):**			
28	a) National Adult Cardiac Surgery Audit (NACSA)	N/A		
	b) National Congenital Heart Disease Audit (NCHDA)	N/A		
	c) National Heart Failure Audit (NHFA)	Yes	Yes	600 cases submitted, ongoing data submission
	d) National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	252 cases submitted, ongoing data submission
	e) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	355 cases submitted, ongoing data submission
	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	N/A		
	g) National Audit of Mitral Valve Leaflet Repairs (MVLR) [estimated start date April	N/A		
	h) The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N/A		
29	**National Child Mortality Database (NCMD)**	Yes	Yes	All deaths of children from the Warrington and Halton areas are discussed at the CDOP (Child Death Overview Panel) and this feeds into the NCMD
30	**National Clinical Audit of Psychosis (NCAP)**	N/A		

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
31	National Comparative Audit of Blood Transfusion:			
	a) 2023 Audit of Blood Transfusion against NICE Quality Standard 138	Yes	Yes	40 cases submitted, ongoing data submission
	b) 2023 Bedside Transfusion Audit	Yes	Yes	Audit postponed from Oct 2023 to March 2024 – data collection still underway
32	**National Early Inflammatory Arthritis Audit**	Yes	Yes	13 cases submitted, ongoing data submission
33	**National Emergency Laparotomy Audit**	Yes	Yes	101 cases submitted, ongoing data submission
34	National Gastrointestinal Cancer Audit Programme (GICAP):			
	a) National Bowel Cancer Audit	Yes	Yes	Latest published data: April 2021 – March 2022 107 cases submitted, ongoing data submission
	b) National Oesophago-gastric Cancer	Yes	Yes	< 10 cases submitted via Royal Liverpool University Hospital
35	**National Joint Registry**	Yes	Yes	Latest published data: April 2021 – March 2022 The Cheshire & Merseyside Treatment Centre (CMTC) 581+ cases submitted, ongoing data submission. WHH 43+ cases submitted, ongoing data submission.
36	**National Lung Cancer Audit (NLCA)**	Yes	Yes	Latest published data: January 2021 - December 2021 222 cases submitted, ongoing data submission
37	**National Maternity and Perinatal Audit (NMPA)**	Yes	Yes	2438 births, ongoing data submission
38	**National Neonatal Audit Programme (NNAP)**	Yes	Yes	292 cases submitted, ongoing data submission
39	**National Obesity Audit (NOA)**	N/A		
40	**National Ophthalmology**	Yes	Yes	781 cataracts in the latest published report April 2021-Mar 2022

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
	Database Cataract Audit			
41	**National Paediatric Diabetes Audit**	Yes	Yes	Latest published data: April 2021 – March 2022 152 cases submitted, ongoing data submission
42	**National Prostate Cancer Audit**	Yes	Yes	Latest published data: April 2021 – March 2022: 148 cases submitted, ongoing data submission
43	**National Vascular Registry (NVR)1**	N/A		
44	**Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)**	N/A		
45	**Paediatric Intensive Care Audit Network (PICANet)**	N/A		
46	**Perinatal Mortality Review Tool (PMRT)**	Yes	Yes	All live birth, up to 28 days of age. More than 22 weeks gestation and any still births are discussed and feed into the National PMRT database.
47	**Perioperative Quality Improvement Programme**	N/A		
48.	**Prescribing Observatory for Mental Health (POMH):**			
	a) Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	N/A		
	b) Monitoring of patients prescribed lithium	N/A		
49	**Sentinel Stroke National Audit Programme**	Yes	Yes	213 cases submitted, ongoing data submission
50	**Serious Hazards of Transfusion UK National Haemovigilance Scheme**	Yes	Yes	12 cases submitted, ongoing data submission

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
51	**Society for Acute Medicine Benchmarking Audit**	Yes	Yes	52 cases submitted
52	**Trauma Audit and Research Network**	Yes	N/A – audit not running	
53	**UK Cystic Fibrosis Registry**	Yes	Yes	25 cases submitted, ongoing data submission
54	**UK Renal Registry Chronic Kidney Disease Audit**	Yes	Yes	Data submitted via Liverpool Royal Hospital. Latest figures 2021. Ongoing data collection: Transplant: 0 adult cases submitted Haemodialysis: 5 adult cases submitted Peritoneal Dialysis: 0 adult cases submitted
55	**UK Renal Registry National Acute Kidney Injury Audit**	Yes	Yes	Latest data submitted to AKI Laboratory Portal in 2022, AKI all stages 1-3. Q1 860 alerts submitted via laboratory (lab) Q2 932 alerts submitted via lab Q3 929 alerts submitted via lab Q4 779 alerts submitted via lab Ongoing data collection

National Confidential Enquiries				
HQIP ID No.	**National Confidential Enquiries**	**Eligible**	**Participated**	**Number of cases submitted**
1.	**Testicular Torsion Study**	Yes	Yes	5 clinician questionnaires and 1 organisational questionnaire were assigned. Both the clinician and organisational questionnaires have been submitted.

National Confidential Enquiries				
HQIP ID No.	National Confidential Enquiries	Eligible	Participated	Number of cases submitted
2.	**End of Life Care: Clinician Questionnaire**	Yes	Yes	4 Clinician Questionnaires were assigned. 2 have currently been submitted.
3.	**Endometriosis**	Yes	Yes	5 Clinician questionnaires were assigned. 4 Clinician questionnaires were submitted. 1 clinician questionnaire is not required to be completed as the Consultant no longer works for the Trust.
4.	**Community Acquired Pneumonia Hospital Attendance**	Yes	Yes	8 clinician questionnaires were assigned and 1 organisational questionnaire. 7 clinician questionnaires have been submitted. 1 clinical questionnaire is not required to be completed as the patient was not suitable. The organisational questionnaire has been completed.

The reports of 27 national clinical audits were reviewed by the Trust in 2023-24, and Warrington and Halton Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2023/24**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
1.	National Neonatal Audit Programme (NNAP) 1st Jan 2021 - 31st Dec 2021	Specific quality improvement programmes have increased the rates of normothermia and breastfeeding on the Neonatal Unit significantly, improving outcomes for parents and babies. Parental presence on the Neonatal Unit was severely affected by COVID-19 and has picked up significantly with renewed focus on family integrated care. Actions: Engagement in MatNeoSIP project training of midwifery, obstetric and neonatal staff on the importance of the development of the preterm birth process to use Lifestart enabling intact cord stabilisation of newborn. Continue quality improvement project using temperature control measures on delivery suite and monitoring of temperature from birth. Ensure records are made on Badgernet when parents have attended ward round. Continue FiCare project to support families to be involved in everyday care – maintain green accreditation. Ensure staff training and parental support to express and deliver colostrum to baby within 24 hours of life. Ongoing support of mother and family to express and establish breastfeeding on the Neonatal Unit.
2.	Paediatric Diabetes (NPDA) 1st Jan 2020 - 31st March 2021	The clinical outcomes continued to be improved and better than national average for HbA1c levels and the percentage of patients receiving sick day rules and flu vaccinations. Actions: Ensure communication to regional eye screening team to obtain annual screen reports. Raise awareness among patients for regular annual eye checks (Digibete APP communication). Training plus raising awareness for junior doctors at induction to ensure completion of Thyroid and coeliac screening and diagnosis followed up.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2023/24**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
3.	National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 1st April 2021 - 31st March 2022	Overall, Health check completion rates better than regional and national average. Actions: Improve annual retinal screening capture information and data. Improve care at diagnosis for carbohydrate counting at diagnosis and ICR within 2 weeks. Improve care at diagnosis for coeliac and thyroid screen. Increasing patients on CGMS by supporting technology training and provision.
4.	National Joint Registry (NJR) 1st April 2021 - 31st March 2022	WHH and the Captain Sir Tom Moore Building are performing within the 'expected' range for hip, knee, elbow, and shoulder replacement surgery. Performance is 'better than expected' in 4 out of the 5 quality measures. No action plan required.
5.	MBRRACE-UK Perinatal Mortality Surveillance Report 2022 1st January 2020 - 31st December 2020	All figures reported are within the expected limits. All stillbirths and neonatal deaths within 28 days have a review, which includes external representation form neonatal, obstetric and midwifery colleagues from the Cheshire and Merseyside Local Maternity System (LMS), and information is sent via the Perinatal Mortality Review Tool, which is nationally adopted and collects this data. The LMS oversees all our data. Actions: Implementation of Badger Notes with multiple language. Patient information leaflets on reduced foetal movements. Implementation of BSOTS Maternity Triage System. Smoking cessation referral opt out not opt in system via BadgerNet referral.
6.	BTS (British Thoracic Society) pleural services organisational audit	This was an organisational audit rather than a clinical data audit however a number of actions were assigned for improvement. Actions:

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2023/24**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		Appointment of Trust pleural lead through recent consultant appointment. Business case for dedicated Pleural Nurse Specialist/Advanced Nurse Practitioner (this is also a GIRFT action). Dedicated pleural service with OP clinics, data capture for Best Practice Tarriff, pleural in-reach and dedicated referrals pathway. Develop indwelling Pleural Catheter Service and medical thoracoscopy. Ongoing pleural Local Safety Standards for Invasive Procedures (LocSSIPs) audits.
7.	National Ophthalmology Database (NOD) Patients starting treatment for neovascular Age-related macular Degeneration (NvAMD) 1st April 2020 – 31st March 2021	The first report of the NOD AMD Audit provides assurance that delivery of NHS-funded treatment for NvAMD is of good quality overall. Actions: Undertake a LOCCSSIP (Local Safety Standards for Invasive Procedures) Audit for intravitreal injections. Maintain a record of complications and keep a record of new patients referred to AMD clinic.
8.	British Association of Urological Surgeons (BAUS) snapshot audit on Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder (MITRE) Audit 1st January 2019 - 31st March 2019	This audit retrospectively looked at 1 month's activity, work several years past to allow adequate follow up. Unfortunately, very limited data was available as the number of patients presenting in that month was low. However, data presented did not deviate significantly from other units submitting similar data. No action plan required.
9.	Diabetic Footcare Audit (NDFA) 1st July 2014 - 31st March 2021 with interactive data for 1st April 2020 - 31st March 2021	The data relating to the Diabetic Footcare Audit is showing no areas of concerns. It is important to note that the data displayed is from the period 2020-2021 which was during the Pandemic, which has resulted in fewer cases referred. Most of the service is managed via community services and is not fully relevant to WHH. The metrics which are relevant are comparable to national outcomes.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2023/24**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		No action plan required.
10.	National Pulmonary Rehabilitation audit (PR) 1st March 2022 - 30th Sept 2022.	The audit measures performance against the 6 Key performance indicators (KPI's). The only KPI which was not met was the six-minute walk tests (6MWT). Actions: Reduce waiting times to start intervention within 12 weeks. Suitable patients will have incremental shuttle walk test as outcome measure. Moving forward the Trust is going to sign up to the accreditation process.
11.	Breast Cancer in Older patient's (NABCOP) 1st January 2014 - 31st December 2019	On the whole there were no areas for concern and the assurance rating is high. Actions: Drill down audit into some of the metrics where the figures are questionable from the summary 2019 data. Start to use Clinical Frailty Scale and Abbreviated Mental Test Score assessments in clinic.
12.	National Lung Cancer Audit (NLCA) 1st January 2021 - 31st December 2021	The Associate Director for Clinical Effectiveness is the lead for this national audit who awarded significant assurance. This was scrutinised by the Clinical Director for Medical Care who was in agreement with significant assurance. Actions: Business case for additional Clinal Nurse Specialist (CNS) recruitment to be presented to the Executive Team (incl. replacement post) in line with national CNS ratios. Commence local Quality Improvement Project (QIP) to improve PCR by working with stakeholders, to be at par or above national standards.
13.	2022 UK Parkinson's 1st May 2022 - 30th September 2022	There were no concerns and high assurance was awarded but the audit results highlighted that WHH are using 'Parkinson's Disease – specific outcome measures' (that look at balance, gait, and bed mobility) but WHH do not routinely use self- reported measures which would evaluate patient's quality of life. This has been included as an action for improvement. Actions:

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2023/24**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		To include the use of an additional evidence-based Parkinson's Disease specific outcome measures, such as the PDQ-39 (license requirement to be considered) in our practice to evaluate patient's quality of life and more patient-centred.
14.	National Bowel Cancer Audit 1st April 2019 - 31st March 2020	The Trust does not appear to be an outlier for any of these performance indicators. Overall, the assurance was high. The only area where WHH fall slightly lower than the network was for laparoscopic surgery being attempted (43) compared with 69 for the network and 71 nationally. Actions: A consideration will be given to offering laparoscopic surgery to future patients.
15.	National Maternity and Perinatal Audit (NMPA) 1st April 2018 - 31st March 2019	Almost all measures are within range limits. The only measure outside normal limits is the Induction of Labour rate (IOL) at 42.9% the mean for all Trusts is 33.5%. At the time of review this data is four years old and therefore not necessarily representative of the current data. Actions: The Director of Midwifery has confirmed that ongoing quality improvement work surrounding IOL is continuing, including the relocation of the induction bay and an introduction of a labour Task and Finish group. This will explore improvements to IOL pathways and a review of criteria. Since this audit was completed, national guidance has changed significantly and therefore it is anticipated that IOL rates will have increased nationally within the next report.
16.	National Heart Failure 1st April 2021 - 31st March 2022	As reported previously an improvement has been seen in the results from audit report for the period 2019 - 2020 and subsequently 2020-2021 data. The improvement has been sustained in the 2021-2022 national report for WHH. No action plan required.
17.	Society for Acute Medicine Audit (SAMBA) 23rd June 2022	The audit results provide a snapshot of care delivered to acutely unwell patients in the UK over a 24-hour period on 23rd June 2022. It is important to point out that at this time the WHH SDEC Unit was not open and functioning on this date. The Lead clinician presented the overview and action plan for improvement at the September Patient Safety and

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2023/24**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		Clinical Effectiveness Sub Committee. The department has since undertaken a re-audit in June 2023 See below.
18.	Society for Acute Medicine Audit (SAMBA) 22nd June 2023	Main findings that have arisen following SAMBA 2023, are around NEWS score being completed within 30 minutes of arrival to hospital. This is expected to have improved with the opening of SDEC, however more work is ongoing with Triage in the Emergency Department. Actions: Development of a Live IT system to allow ongoing review of the findings. Planned increase in Consultant rota during the day to provide appropriate review of patients. It is known high numbers of patients can impede on this.
19.	NRAP's (National Respiratory Audit Programme) Children and Young People Asthma 1st October 2022 - 31st March 2023	Although the audit was completed on a small sample (13 patients) it demonstrates compliance with the metrics. WHH are highlighting the need to ensure that inhaler technique is checked & documented, along with the giving out of the personalised asthma management plans. Actions: Inhaler technique to be checked at discharge. Issue personalised asthma plans (PAP).
20.	Perinatal Mortality Surveillance Report Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) 1st January 2021 - 31st December 2021	As required WHH reported 100% of stillbirths and late fetal losses within 7 days. There were no neonatal deaths within the Trust during 2021. Actions: Implement all standards in all elements of Saving Babies Lives Care Bundle (SBLCB3) 2023 by March 2024
21.	Cardiac Rhythm Management (CRM) 1st April 2021 - 31st March 2022	For data completeness: compliance was greater than >95% in all of the compulsory fields. The audit demonstrated compliance with NICE TA88 and TA314 was 100%. There were no reported re-interventions within 1 year. No action plan required.
22.	Myocardial Ischaemia National Audit (MINAP) 1st April 2021 - 31st March 2022	The results show a high proportion of Acute Coronary Syndrome (ACS) patients having echo performed during admission – marginal drop from previous year. A high proportion of ACS patients being reviewed by cardiology

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2023/24**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		during inpatient stay, 99% compared to 97.7% in previous audit. Referral to cardiac rehab remains high. Actions: Review how we add angiogram information to data. Review how we record discharge medication – WHH vs Liverpool Heart and Chest Hospital (LHCH).
23.	National Audit of Dementia (NAD) 19th September 2022 - 31st January 2023	WHH scored higher than the national figures in most of the metrics with the exception of 'Carer rating overall care quality' 61% compared to 66% nationally and 'Carer rating communication' 52% compared to 60% nationally. Actions: LOS to be explored a part of the planned improvements to 4AT screening. Initiate a project to increase 4AT screening in the organisation.
24.	National Emergency Laparotomy Audit (NELA) 8th Year 1st December 2020 - 30th November 2021	Although the final report with adjusted mortality has not yet been published. The report has shown consistently high assurance. No action plan required.
25.	National Comparative Audit of Blood Transfusion 1st January 2022 - 31st December 2022	This audit is essentially an organisational audit and is not really designed as a comparator of WHH performance against national standards. WHH is in line with regional average for rejections, but there are 2 target groups for improvement: • The rate of error made by doctor's and midwives. • The error rate in the community requests. Actions: These will be discussed with the relevant leads going forward.
26.	The National Diabetes Inpatient Safety Audit (NDISA) 1st January 2022 - 31st December 2022	Although it is not an audit as such it measures the frequency of avoidable diabetic harms. The data is discussed regularly at audit meetings. There were no causes of concern therefore high assurance was awarded.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2023/24**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		No actions required.
27.	The National Asthma and COPD Audit Programme (NACAP) - Regional report on Chronic Obstructive Pulmonary Disease (COPD). 1st October 2022 - 31st March 2023	All metrics scored satisfactory. One of the metrics - Acute treatment with Non-Invasive Ventilation (NIV) within 2 hours of arrival, did not have sufficient patients to receive a score (<5 patients). No actions required.

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

The reports of 28 local clinical audits were reviewed by the Trust in 2023-24 with actions in progress to improve the quality of healthcare provided. The table below details a sample of local audits undertaken.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
Clinical Support Services		
1.	CT virtual colonoscopy audit	Success that one of the busiest services in the region is achieving very high standards with no perforations and achieved minimum standard or better in all areas. Actions: Education of junior Radiographers to determine pathology within the bowel.
2.	HASTE Study: Hip & femoral fracture anticoagulation surgical timing evaluation	Anti-coagulated patients on average went to surgery quicker than non-anticoagulated patients and more received surgery within 36 hours. Our patient's mean American Society of Anaesthesiology (ASA) grades were higher than the national mean for all types of fractures. As a Trust we meet British Orthopaedic Association (BOA) standards on having a protocol for reversal of anticoagulation, however we fail to meet the BOA standard for recommended surgery time regularly.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Actions: Continually monthly reviews of neck of femur (NOF) Best Practice Tariff data to review any short comings. Consultant job plan reviews to allow for operating time to run till 18:30 Monday-Friday.'
3.	Re-audit of turnaround time for lymph node biopsy specimens sending to HODS from WHH pathology.	This re-audit covered a period of 3 months prior and 3 months after the new standard operating procedure (SOP) was introduced. This re-audit showed a small improvement. Compliance of 18% in the 2021 audit improved to 36% at the 3 months period prior to new SOP with further improvement to 55% compliance after the SOP was put in place. Unfortunately, this is still very low compliance and further improvement should be made. This is with regards to new lymph node samples. Actions: The new SOP (SOP NUMBER: HC-PA-38) needs to be followed in the Histopathology Lab and to be communicated to all Histopathology staff members which are involved in processing the samples from lymph node biopsies.
Corporate Services		
4.	Trust wide Discharge Summaries	There is an overall improvement in the quality of completion of discharge summaries as compared to the last audit for Planned and Unplanned Care which provided moderate assurance only. Actions: Disseminate to junior doctors to complete information on new Acute Kidney Injury (AKI), falls and blood transfusion. Review discharge summary template miscellaneous section, to improve completion of the AKI section, falls and blood transfusion.
5.	Trust wide Clinical Documentation Audit	There were 3 elements of the audit that scored below 90% compliance and were therefore marked as amber compared to the previous audit. Actions: Documentation audit & ward audit & associated actions to be shared at governance meetings and with ward staff.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Lead nurses to note the additional audit and progress in their high-level briefing papers (HLBP) until associated actions complete. Share single point lesson on standards of record keeping with the ward managers for dissemination. Ward level audit in January in conjunction with the quality metric. Ward managers to add the results and associated action plans in the February action plan.
6.	Falls audit 2023	Improvements were seen compared to the previous audit. For example. 52% of patients audited had a falls risk assessment completed within 6 hours of admission to the ward compared to the previous audit of 39%. 50% of patients audited had a bed rail assessment completed within 6 hours of admission to the ward, with a further 45% being completed after 6 hours. This is an improvement from only 14% in 2022. 84% of patients audited where identified as a falls risk compared to the previous audit of 81%. There was no evidence of a bed side eyesight test being done in both 2022 and 2023 audits. Actions: An environmental falls risk bathroom audit to be completed. Complete a thematic review for all the falls with harm during the period of April 2022- March 2023. Devise a 'falls risk prompt sheet' for ward staff to utilise for patients identified as a falls risk. Development of a bed side eyesight check.
7.	Staffing escalation audit	There was always a record of staff moves for the long day with a plan for the twilight and night. There was not always evidence on gold command of areas with outstanding red flags or amber staffing of review and closure of red flags. There has been an increase in red flags raised by wards to highlight concerns which are discussed in the twice daily staffing meetings.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Actions: All matrons/lead nurses to ensure all ward skill mix is recorded on gold command. Spot checks of gold command daily during March 2024. All matrons/lead nurses to ensure all ward staffing numbers are recorded on gold command including weekend/bank holidays. Ensure any staff moves made during the day are recorded on gold command, particularly out of hours: Ensure review of red flags is recorded on gold command and red flag narrative or closure is recorded.
	Digestive Diseases	
8.	Re-audit of the assessment of administration of prescribed medications in pre-operative trauma patients.	The audit showed compliance with local and national guidance for medicines management while patients were 'nil by mouth' was low. Simple interventions designed to improve understanding and adherence to these polices had a positive impact with a reduction in inappropriate medication omissions. However, this reduction was not shown to be sustained during the short re-audit cycle window. Actions: Education on the guidelines regularly delivered to all doctors and nurses caring for pre-operative trauma patients. Physical copy of the local guidelines placed on all pre-operative wards for reference. Audit findings to be shared and distributed with relevant departments (Anaesthetics, Trauma).
9.	Re-Audit of the evening surgical handover against the RCSENG Safe Handover Guidance	When the team member leading the handover used the handover template guidance, created following the initial audit in September 2023, the key aspects of a safe and effective handover were carried out as per The Safe Handover: Guidance from the Working Time Directive working party (2007) by the RCS England. Actions:

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Improve handover template, introduce in the next induction meeting.
10.	Oesophageal stent audit	The audit showed that oesophageal stent insertion can be done locally at DGH if skills are available, with high success rates. However, documentation needs to be clearer in terms of prescribing pain relief and diet post insertion. Actions: Analgesia post stent insertion and diet plan post stent insertion add to SOP and endoscopy report. To have dedicated slot on endoscopist list - Discussion with endoscopy booking / lead.
Integrated Medicine & Community		
11.	Re-Audit of measurement of lying and standing (L/S) blood pressure (L/S BP) in patients above 65 in ward	It is observed from the audit that there is an improvement in measuring lying and standing blood pressure after the action plan implemented in the first audit cycle from 32% to 62%. Actions: Include lying and standing blood pressure record (paper)into multifactorial fall risk assessment booklet. Modify the lying and standing blood pressure recording form as per Royal College of Physicians guidelines.
12.	Venous Thromboembolism (VTE)	Improvement is needed in all standards to prevent deep vein thrombosis (DVT) and pulmonary embolism (PE) in patients with acute stroke. VTE prophylaxis guidance in stroke patients is different from general medical patients and every new doctor coming to work to the stroke ward needs to be aware of the guidelines. There is a need to develop a local consensus for VTE prophylaxis in the stroke Unit. Actions: To develop departmental protocol for VTE prophylaxis in stroke patients. To include Prevention of VTE as a topic in ward induction presentation.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		To make laminated posters of flow chart for VTE prophylaxis in stroke patients. To appoint a ward VTE champion.
13.	Re audit of antiresorptive treatment and Vitamin D deficiency in fragility fractures (secondary prevention)	This audit highlighted the need for improved bone protection education for medical professionals, the standardisation of protocols for inpatients. For patients not hospitalised, assessment for bone protection and Fracture Risk Assessment Tool (FRAX) score should be recommended in the discharge summary to be followed up in clinic or GP settings. Actions: Educate doctors and Advanced Nurse Practitioner's (ANPs) in ED, Orthopaedic Department and acute medical ward and inform about standardised care of fragility fracture patients. Deliver board round teaching. Repeat vitamin D level in patients if not done over the past year.
	Medical Care	
14.	Audit to study new referrals to diabetic retinopathy service at Warrington Hospital.	There has been an increase in total number of patients seen compared to previous 12 months. Almost full compliance with National Screening Committee (NSC) guidelines Actions: Look at wording on patient letters to make sure importance of attending is clear. Consider adding conditional statement on diabetic letters.
15.	Rheumatology referral pathways/use of General Practitioners (GP's)	The audit showed that 33% of the patients were referred incorrectly. 3 Temporal arteritis referrals did not use the dedicated pathway. Actions: Rheumatology referral pathways/use of General Practitioners.
16.	Are current staffing levels appropriate to facilitate the safe delivery of high quality, evidence based follow up care to cardiac	Virtual session demand has significantly increased since 2019. Routine device clinics are currently 7 sessions per week. Data suggests that 5- 7 device sessions (not including virtual sessions) per week would be sufficient. Current staffing level is 2 full time equivalent device

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
	device patients based on British Heart Rhythm Society (BHRS) Guidelines	Physiologists. Data suggests that 4 full time equivalent device Physiologists are required. Data suggests a deficit of 2 full time equivalent device Physiologists. Actions: Increase staffing by 2x qualified pacing Physiologists. Reduce face to face clinical sessions (from 5 to 7) Implementation of Pacenet database. This will save time & reduce risk of human error due to frequent duplications. Outsourcing some remote monitoring to focus on until staffing levels are increased.
17.	Monitoring of blood glucose in Respiratory patients on Glucocorticoid therapy	Our data showed that 63% of the patients in Respiratory Ward were started on steroids during the month of October 2022. The audit standard set by Joint British Disease Society (JBDS) for inpatients treated with steroids screened for hyperglycaemia with blood glucose monitoring is 90%. This standard, at 45.8 %, was not met. 65% of diabetic patients started on steroids, did not have CBG (capillary blood glucose) monitored QDS as per JBD guidelines. The rest 35% of diabetic patients had CBG monitoring done QDS but not daily. Actions: Education of the staff working in Respiratory Medicine Create local Guideline for monitoring and management of steroid induced hyperglycaemia with input from Diabetes and Endocrine Team.
	Surgical Specialities	
18.	British Orthopaedic Association Standards for Trauma (BOAST) fracture clinic service and virtual fracture clinic	Seen within the 72-hour target there has been improvement to 60.4% from 5.9% with the introduction of virtual fracture clinic. Actions: Introduction of eTrauma. Update Trauma & Orthopaedic SOP for fracture referral and management.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
19.	Compliance with NICE guidelines on the early and appropriate management on pain in fracture Neck of Femur (NOF) patients.	Pain was found to be well assessed at initial assessment. Actions: Clearer documentation of pain reassessment after 30 minutes. Increase nerve block administration in the Emergency Department. Quicker administration of analgesia after initial assessment.
20.	Long term XEN implant outcomes	Overall key findings confirmed Micro-invasive glaucoma surgery (MIGS) is a safe procedure with comparable results to those find in the literature. The success rate of our MIGS procedures is comparable and within target set out in the literature. The reduction in glaucoma medication eye drops is significant post procedure and complication rate is low. Actions: Update the current WHH MIGS leaflet to include IOP lowering & complication rate. Update WHH MIGS leaflet to include complication rate.
21.	Audit of prostate cancer fast track	Achieved the goal of 2 week wait referral and the patients being seen within 2 weeks (95%). Actions: Recruit triage Clinical Nurse Specialist. Update the Histopathology and Radiology Department's with the audit findings.
Urgent & Emergency		
22.	First seizure management in Emergency Department (ED)	The audit results demonstrated that we are good at the following: Documenting accurate medical history. Investigating as per 1st fit pathway. Safely discharging and admitting appropriately. Referring relevant cases to Neurology. However, driving and occupational advice in was only given in 57% of relevant cases.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Actions: Provide driving and occupational advice to all relevant 1st seizure patients as per Royal College of Emergency (RCEM) standards. To make available printable advice leaflets in ED.
23.	To Assess the management of children under 5yrs who attend Paediatric ED who trigger the Sepsis Pathway	Initial audit so no data to compare with. Pathways are needed to help identify that 1 septic patient amongst the viral patients. A senior clinician needs to sign a child off the pathway. Actions: Raise awareness/as a reminder of the sepsis pathway and triage tool. Devise a single point lesson PowerPoint presentation & share with Paediatric ED.
24.	Re-audit of the effectiveness of triage stickers in triage time in Same Day Emergency Care (SDEC)	Observations from the audit indicate significant improvements in triage time after the implementation of triage stickers. The data reveals a notable improvement to 62.5% in triage time within 15 minutes. 87.5% of patients were triaged within 30 mins of arrival to SDEC, demonstrating a significant decrease to 12.5% in instances of longer triage times. Actions: Emphasize the importance of triage timings during multidisciplinary team (MDT) meetings. Discuss the positive impact of stickers on triage efficiency and encourage staff to prioritize timely triage. Incorporate training sessions for new staff members to highlight the significance of triage stickers. Consider review of staffing between the hours of 12-5pm to improve compliance with the target of 100% of patients having triage completed within 15 minutes of arrival.
Women & Children		
25.	The antenatal management of diabetic patients	Overall excellent compliance to national recommendations. Actions:

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		To add a compulsory tick box field to antenatal clinic assessments in the 'Badger-net' electronic patient records. This must be ticked when the management plan has been discussed with the patient. This will prompt the clinician to discuss the management plan.
26.	Chronic hypertension in pregnancy	2 out of the 3 women booked at less than 12 weeks, one booked at 15 weeks. 100% were risk assessed at booking. 100% were recommended aspirin. Actions: Add APEC information to BadgerNet. Document delivery planning – NICE recommends from 37 weeks. Mention preconception clinics after birth. All women with hypertension or any maternal medical conditions should be booked by 10 weeks. All women with chronic hypertension should be seen in the joint anti-natal clinic/medical disorders weekly clinic.
27.	Re-audit of Female Genital Mutilation (FGM)	Identified survivors of FGM are appropriately referred to services to safeguarding their unborn and other children. Whilst the data collection form is not always fully completed, this is often because the survivor is unaware of the information. No action plan required.
28.	Re-audit of System-wide Paediatric Observations Tracking (SPOT)	The majority of standards were met and improved from the last audit. however, there was Amber Compliance with the recognition and escalation of Low-risk scores (1-4). (SPOT Team are revising parameters and escalation process in relation to a score 1-2). Actions: Single Point lesson to be sent to staff raising awareness regarding importance of documentation and escalation of risk (Paediatric Early Warning Signs)

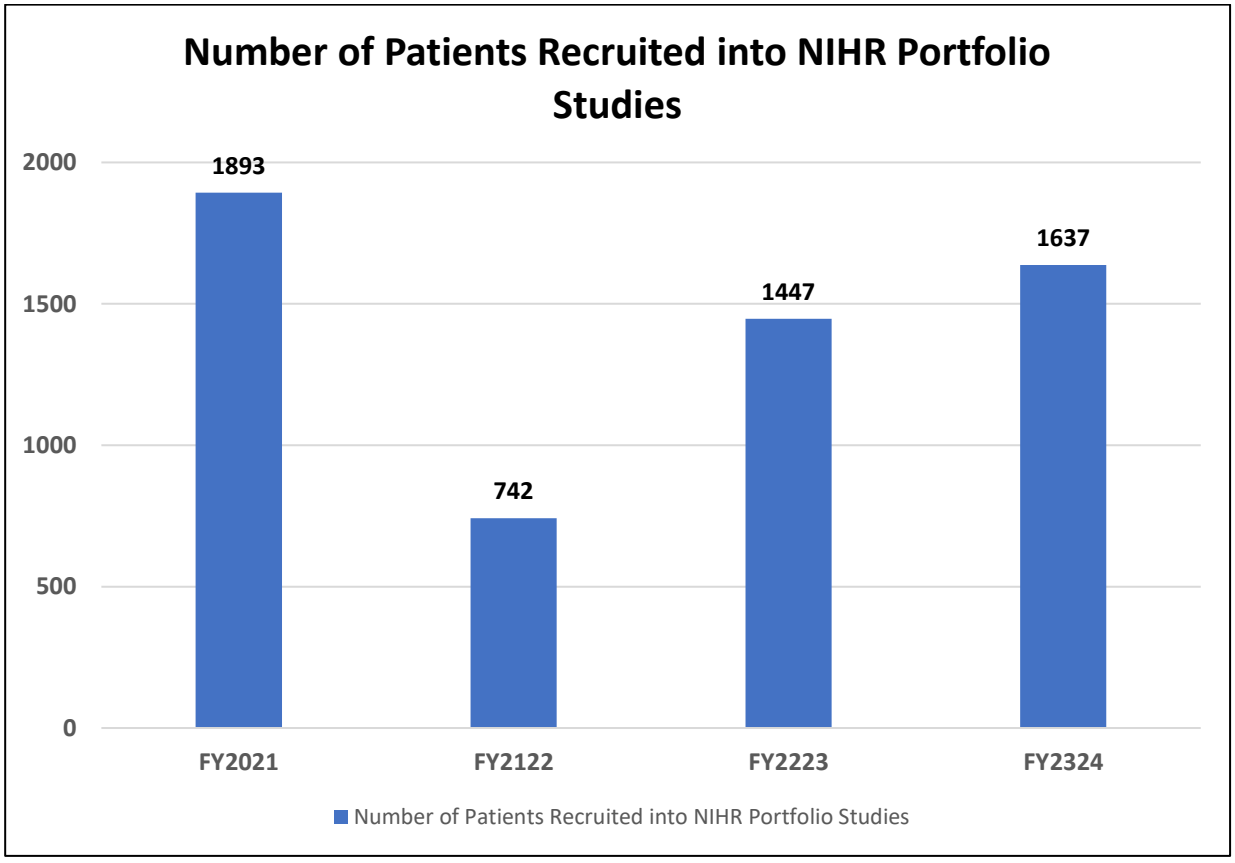
2.7 Information on Participation in Clinical Research Development 2023-24.

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

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

Overview of Research Activity

The number of patients receiving relevant health services provided or sub- contracted by Warrington and Halton Teaching Hospitals NHS Foundation Trust in 2023/24 during that period to participate in research approved by a research ethics committee was 1449 (95% growth) when compared to the previous financial year). It should be noted that in 2023-24, NIHR Portfolio Study data is not signed off nationally until 30 June 2024 and the patient participation figure is, therefore, un-validated at this time.



Data Source: NIHR Open Data Platform.

The National Institute of Health and Care Research (NIHR) portfolio studies are high quality research that have full funding and have undergone a rigorous peer review in order for them to be adopted onto the portfolio.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust was involved in conducting 23 clinical research studies during 2023-24, covering 14 healthcare specialties as outlined in the Table below.

Study Type	Study Sponsor	Managing Speciality	Short Name	Study Title	Recruitment
Non-Commercial	University of Nottingham	Reproductive Health and Childbirth	Routine testing for Group B Streptococcus	The clinical and cost-effectiveness of testing for Group B Streptococcus: a cluster randomised trial with economic and acceptability evaluations (GBS3)	1142
Non-Commercial	University of Leicester	Ageing	CHARMER WP4 Definitive Trial	Comprehensive Geriatrician led Medication Review (CHARMER) - Work Package 4 Definitive Trial	194
Commercial	MODERNA, INC.	Infection	mRNA-1283-P301 COVID-19 Booster Age 12 +	A randomized, observer-blind, active-controlled Phase 3 study to investigate the safety, immunogenicity, and relative vaccine efficacy of mRNA-1283.222 administered	96

Study Type	Study Sponsor	Managing Speciality	Short Name	Study Title	Recruitment
				as a booster dose compared with mRNA-1273.222 in participants aged 12 years and older for the prevention of COVID-19	
Non-Commercial	INTENSIVE CARE NATIONAL AUDIT AND RESEARCH CENTRE (ICNARC)	Critical Care	UK-ROX	Evaluating the clinical and cost-effectiveness of a conservative approach to oxygen therapy for invasively ventilated adults in intensive care.	88
Non-Commercial	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	Anaesthesia, Perioperative Medicine and Pain Management	The POPPY Study	Patient reported outcomes, postoperative pain and pain relief after day case surgery	54
Non-Commercial	BELFAST HEALTH AND SOCIAL CARE TRUST	Critical Care	MARCH	Mucoactives in Acute Respiratory failure: Carbocisteine and Hypertonic saline	11
Non-Commercial	LOTHIAN	Critical Care	GenOMICC	Genetics of susceptibility and mortality in critical care (GenOMICC)	8

Study Type	Study Sponsor	Managing Speciality	Short Name	Study Title	Recruitment
Non-Commercial	University of Oxford	Trauma and Emergency Care	CRAFFT – Children's Radius Acute Fracture Fixation Trial	CRAFFT – Children's Radius - Acute Fracture Fixation Trial: A multi-centre prospective randomised non-inferiority trial of surgical reduction versus non-surgical casting for displaced distal radius fractures in children.	5
Non-Commercial	University of Nottingham	Stroke	Pharyngeal Electrical stimulation (PES) for Post Stroke dysphagia (PSD	Pharyngeal Electrical stimulation for Acute Stroke dysphagia Trial (PhEAST)	5
Non-Commercial	University of Oxford	Critical Care	Threshold for Platelets Study (T4P)	The Threshold for Platelets (T4P) study: a prospective randomised trial to define the platelet count below which critically ill patients should receive a platelet transfusion prior to an invasive procedure	5

Study Type	Study Sponsor	Managing Speciality	Short Name	Study Title	Recruitment
Non-Commercial	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	Musculoskeletal Disorders	RaCeR 2	Clinical and cost-effectiveness of individualised (early) patient-directed rehabilitation versus standard rehabilitation after surgical repair of the rotator cuff of the shoulder: a multi-centre, randomised controlled trial with integrated Quintet Recruitment Intervention	5
Non-Commercial	LOTHIAN	Critical Care	The ABC post-intensive care trial	Anaemia management with red Blood Cell transfusion to improve post-intensive care disability: a randomised controlled trial	4
Non-Commercial	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	Critical Care	MOSAICC	Evaluating the clinical and cost-effectiveness of Sodium Bicarbonate administration for critically ill patients with Acute Kidney Injury and metabolic acidosis	4

Study Type	Study Sponsor	Managing Speciality	Short Name	Study Title	Recruitment
Non-Commercial	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	Hepatology	NAFLD BioResource	The NAFLD BioResource, part of the NIHR BioResource – A Research Study to Characterise Novel Clinical and Genetic Phenotypes, and Understand the Natural History of Non-Alcoholic Fatty Liver Disease (NAFLD)	3
Non-Commercial	University of Nottingham	Reproductive Health and Childbirth	Smoking, Nicotine and Pregnancy 3 (SNAP 3) Trial	Open label randomised controlled trial of enhanced support and nicotine replacement therapy (NRT) offered for preloading, lapse recovery and smoking reduction: impact on smoking in pregnancy	3
Non-Commercial	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Gastroenterology	IBD Bioresource	The UK Inflammatory Bowel Disease Bioresource: Progressing from Genetics to Function and Clinical Translation in Crohn's Disease & Ulcerative Colitis	2

Study Type	Study Sponsor	Managing Speciality	Short Name	Study Title	Recruitment
Non-Commercial	University of Aberdeen	Children	SPIROMAC	Spirometry to Manage Asthma in Children (SPIROMAC)	2
Non-Commercial	University College London	Anaesthesia, Perioperative Medicine and Pain Management	Perioperative Quality Improvement Programme: Patient Study	Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme	1
Non-Commercial	University of Liverpool	Ophthalmology	Visual scanning training for hemianopia	A randomised controlled trial of scanning eye training as a rehabilitation choice for hemianopia after stroke (SEARCH)	1
Non-Commercial	Ottawa Hospital Research Institute (Canada)	Reproductive Health and Childbirth	FACT 4 Child	Folic Acid Clinical Trial: Follow up of children (FACT 4 Child)	1
Non-Commercial	University of Ulster	Critical Care	iRehab	Remote rehabilitation after ICU (iRehab)	1
Non-Commercial	University of Edinburgh	Surgery	MOTION Trial Protocol V1.0	What is the clinical-effectiveness and cost-effectiveness of surgery with medial opening wedge high tibial osteotomy (HTO) compared with non-surgical treatment in the management	1

Study Type	Study Sponsor	Managing Speciality	Short Name	Study Title	Recruitment
				of osteoarthritis (OA) of the knee in patients younger than 60 years? (MOTION Trial)	
Non-Commercial	University of Southampton	Mental Health	ProACTIVE National Survey of Hospital-based Provision of Alcohol Care	Programme of research for Alcohol Care Teams: Impact, Value and Effectiveness (ProACTIVE): Understanding the Provision in Acute Care in Hospitals Nationally (WP1a+)	1

Data Source: NIHR Open Data Platform.

Growth in Commercial and Non-commercial Portfolios

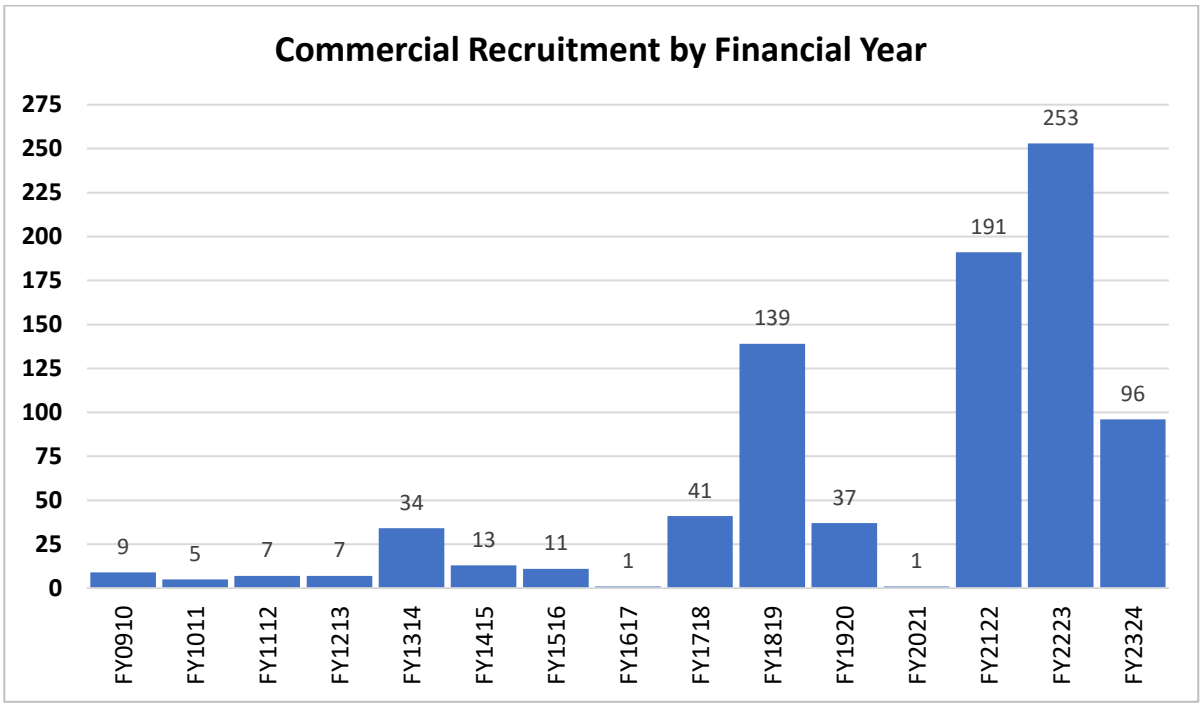
The NIHR Portfolio includes both commercial and non-commercial studies. Warrington and Halton Teaching Hospitals, NHS Foundation Trust are pleased to have been able to increase the research opportunities for patients across both commercial and non-commercial portfolios.

The following tables demonstrate the NIHR Portfolio studies opened to recruitment in year for both commercial and non-commercial studies in FY2022-23 and FY2023-24.

	Commercial		
	FY 2022-23	FY 2023-24	% Improvement
Number of studies opened	3	1	-66.7%
Number of participants recruited	253	96	-62.1%

	Non-Commercial		
	FY 2022-23	FY 2022-23	% Improvement
Number of studies opened	16	22	37.5%
Number of participants recruited	1191	1541	29.4%

Data Source: NIHR Open Data Platform.



Data Source: NIHR Open Data Platform.

The RD&I department continue to work in collaboration with Halton Clinical Research Unit (HCRU) partners, National Institute for Health Research (NIHR), Clinical Research Network Northwest (CRN NWC) and Liverpool University Hospitals NHS Foundation Trust (LUHFT). Recruitment to commercial studies on the HCRU has decreased from 253 in FY22-23 to 96 in FY23-24.

The Partnership is overseen by the Research Partnership Board, consisting of senior representatives from each of the HCRU partners (Clinical Research Network North West Coast and Liverpool University Hospitals Foundation Trust). The Partnership Board has been an essential oversight and action group, supporting Warrington and Halton Teaching Hospitals, Foundation Trust in establishing itself as a preferred site for phase II+ commercial research studies with a good reputation for delivery to time and target.

Improving the offer of research opportunities to patients

Scoping for new studies

RD&I scope out new studies for WHH through an “expressions of interest” portal and proactive approaches to research teams and commercial sponsors. 443 studies were assessed for suitability with 36 resulting in an expression of interest being submitted in FY2023-24. This

process aims to broaden the scope of research offered, while also securing a robust pipeline of forthcoming clinical trials and commercial income.

Of the 400 studies that were declined, the chief reasons were no specialist service (214, 53.5%)), no interest in the relevant clinical service (51, 12.8%)), unsuitable study design (34, 8.5%) and capacity of principle investigators (32, 8.0%).

Developing Principal Investigator Capacity

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

- A scheme for Nurses Midwives and Allied Health Professionals (NMAHPS) led by a research active advanced physiotherapist, to develop a programme of capacity and capability building initiatives.
- Embed research training in the Preceptorship Training Programme to ensure new starters are aware of the value of research and have the information required to identify research opportunities and further learning.

Reputation and recognition

Elevating WHH's research reputation helps to attract new studies as well as raising awareness among patients and the public about opportunities for involvement. Notable recognitions in 2023/24 highlight WHH RD&I's commitment to excellence:

- Securing the prestigious 'Research Delivery Team of the Year' accolade at the Northwest Coast Research and Innovation Awards 2023.
- Local and regional press coverage through impactful press releases celebrating International Clinical Trials Day in May 2023.
- Highlighting the 'Power of Partnerships' in a presentation at the Annual Research and Development Forum conference in May 2023.
- Engaging the community through the 'Red for Research' social media campaign on June 16th.
- Showcasing the NMAHP Capability Building initiative at the 'Grow your Own Brilliance' Research Conference, led by Research and Development Northwest in March 2024.

Improving Access to Clinical Trial Opportunities - Pathway to Research

In 2023 a registry called Pathway to Research was launched for patients who would like to hear directly about research opportunities available. This will enable patients to access new research in a timely way and provide another avenue of recruitment for research at the Trust. To date 241 people have consented to the register since the soft launch in January 2023.

Building strategic partnerships with the broader academic, health, and care sectors is paramount. These collaborations provide valuable insights from shared experiences and continuous improvement but also showcase the tangible impact of research initiatives. By fostering such alliances, we enhance the quality and relevance of research offerings, ultimately ensuring better outcomes for patients.

Learning from Experience

Team Affina Journey

The RD&I Team embarked on the Affina Team Development journey aligning with Pharmacy and Finance colleagues to solidify team objectives and enhance role clarity. Health Innovation Northwest Coast, joined on the second session to shed light on avenues for RD&I and WHH to leverage innovation efforts. The Affina Journey not only fosters cohesion within the team which spans two sites, but also serves as provides valuable cross-system learning experiences, enriching their understanding of working within the broader healthcare landscape.

Grow Your Own Brilliance

Team members attended this conference hosted by R&D Northwest focussed on talking, sharing, showcasing, developing and imagining how a career in health and care research can grow. The event provided an opportunity to network and share best practice.

Principal Investigator Forum

A new Research Principal Investigator (PI) Forum launched in February 2024. The forum will serve as a platform for Research Principal Investigators and Associate Principal Investigators engaged in research projects, offering an opportunity to share best practices, formulate strategic approaches for portfolio diversification and growth, and contribute to the sustainability of our research endeavours.

The primary aim of the PI Forum is to foster a collaborative environment, promoting knowledge exchange, facilitating networking, and collectively addressing the common challenges encountered by Principal Investigators.

Chaired by Deputy Associate Medical Director, it was attended by our research leaders from Gastroenterology, Anaesthetics, Microbiology, Speech and Language Therapy and Intensive Care. A previous ICU trainee also provided an insightful presentation about the Associate Principial Investigator Scheme, a six month in-work training opportunity, providing practical experience for healthcare professionals starting their research career.

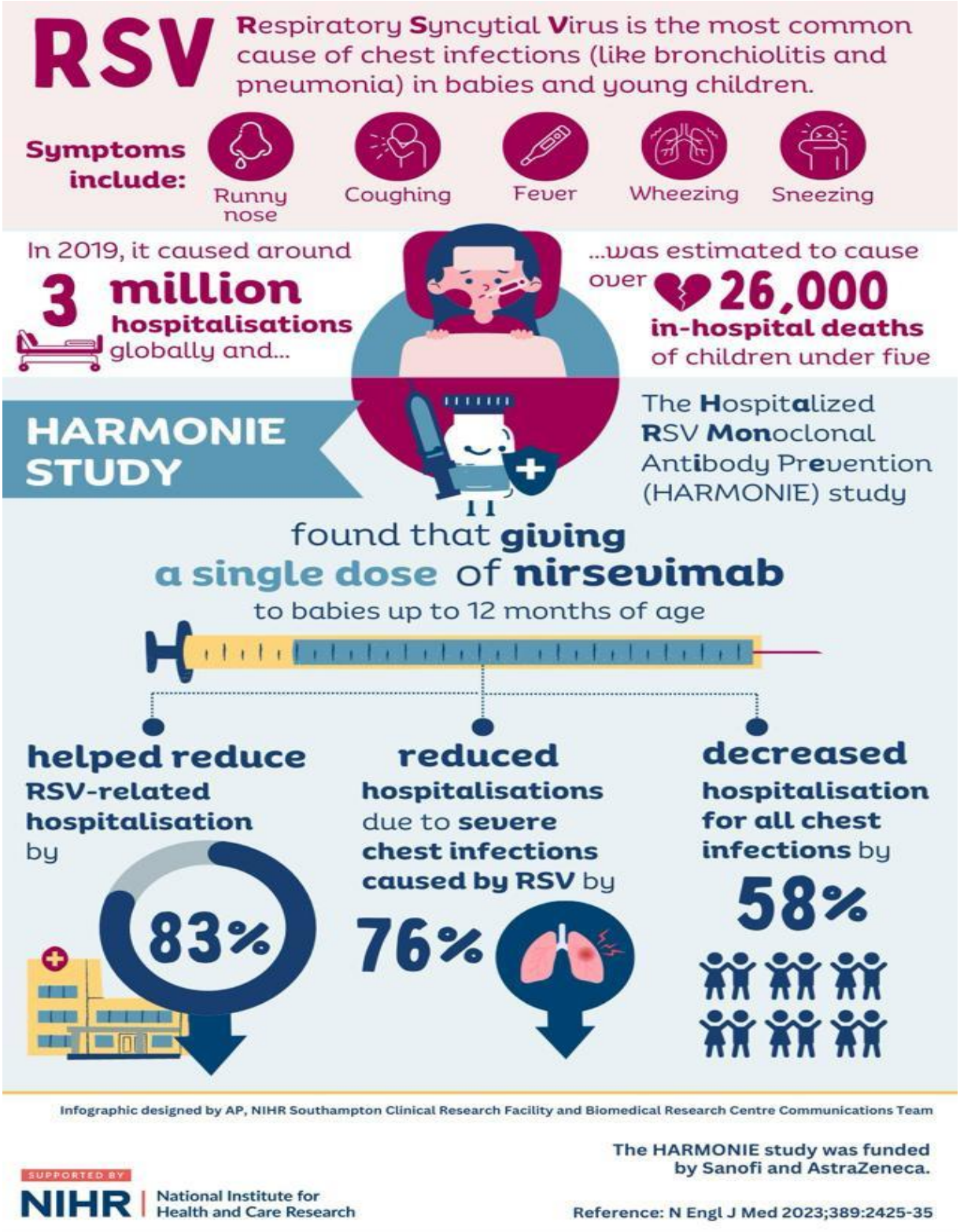
Impact

Impact of Research Study Harmonie

The HCRU successfully opened the first paediatric study, HARMONIE, in November 2022, investigating the immunological response to a single antibody dose of Nirsevimab for Respiratory Syncytial Virus (RSV).

RSV is a common lower respiratory tract infection which causes few issues for the majority of children. However, it does have the potential to lead to severe disease and hospitalisation, which can in turn lead to longer-term health consequences, and, tragically, death. The study aimed to reduce these RSV-related hospitalisations.

The results for this study were published in the New England Journal of Medicine in 2024 and comes with a poster summarising the findings (below). Amazingly, Nirsevimab reduced RSV-related hospitalisations by 83%, not only reducing the burden of disease on infants and their families, but also reducing pressure on limited hospital resources.



Recruitment Performance

The positive impact of WHH's committed workforce and sustained research efforts is clearly demonstrated by the notable growth in recruitment to research studies. In year FY22-23, a total of 1447 participants were successfully recruited across 19 studies within the NIHR Portfolio.

The national data set for recruitment is yet to be confirmed, however preliminary data shows recruitment for FY23-24 to all NIHR Portfolio studies to be 1637, achieved over 22 studies across 14 specialities. 96.2% of recruitment has come from 5 studies.

Short Name	Recruitment	% of Total Recruitment
Routine testing for Group B Streptococcus	1142	69.8%
CHARMER WP4 Definitive Trial	194	11.9%
mRNA-1283-P301 COVID-19 Booster Age 12 +	96	5.9%
UK-ROX	88	5.4%
The POPPY Study	54	3.3%

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

Research Impact on Care Quality Commission rating in Maternity Services

The positive influence of ongoing research activities in Maternity Services at WHH has been reflected in the outcomes of the recent CQC Inspection across Maternity Services. The inspection report highlights the organisations commitment to fostering a culture of innovation and active participation in research initiatives. Leaders at WHH are recognised for not only encouraging but also celebrating innovation and research engagement within the maternity services.

A key highlight in the report is the significant involvement of the service in various research studies. This is facilitated by the dedicated efforts of a research nurse and a research midwife, working collaboratively with obstetric colleagues to support and advance research within the division. The presence of such specialised roles emphasises WHH's commitment to integrating research seamlessly into the fabric of its services.

Notably, WHH has garnered recognition as one of the highest recruiters to research studies in the Northwest region. This acknowledgment is a testament to the organisations proactive approach to advancing medical knowledge and contributing to research initiatives in the field of Maternity Services.

In essence, the positive outcomes of the recent CQC Inspection highlight WHH's leadership in promoting a research-oriented culture within Maternity Services, ultimately positioning the organisation as a significant contributor to healthcare research in the broader Northwest region.

Impact of Strategic Funding secured

The Clinical Research Network (CRN) invited recipients of strategic funding to present their projects at a celebration event in March 2024. WHH had two funded projects that demonstrated positive impact.

Halton Clinical Research Alliance (HCRA): The HCRA is a joint project between WHH R&D and Castlefields Health Centre teams to increase research activity across Halton. The focus for the year was to form a support network for research active practices and explore working modalities for research delivery in primary care across Halton. The funding from the CRN has helped to establish the groundwork required to support practices through their research journey.

The partners in this project will continue with the HCRA unfunded.

Capacity building in NMAHPs: A significant milestone was reached with the appointment of Jo Thomas, a physiotherapist, as the NMAHP research champion. Jo has shown exceptional leadership, forming an NMAHP research group and offering vital guidance to those starting their research journey. The launch of a Research Champion pilot program, Preceptorships Training, and a webinar series has further supported this effort. As a result, the number of NMAHP Principal Investigators has grown to 5, with 2 Associate Principal Investigators. This initiative also helped to secure one of the Applied Research Collaboration Internship in Orthotics.

Strategic Alignment

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

Halton Clinical Research Unit

RD&I are actively pursuing strategic alignments and collaborations with academic institutions and across the wider system with other NHS organisations in the primary and secondary and tertiary care setting. Recent discussions with The Clinical Research Facility Director at Liverpool University Hospital Foundation Trust have explored potential collaborations with Clatterbridge and Liverpool Heart and Chest Hospital. This initiative aims to broaden the scope of commercial clinical trials offered, while also securing a robust pipeline of forthcoming clinical trials. By leveraging these partnerships, RD&I seeks to enhance its capacity for groundbreaking research and innovation, ultimately driving improvements in patient care and outcomes.

Primary Care

Establishing relationships within Primary Care is a key focus, exemplified by the established partnership with Castlefield's and the Warrington Innovation Network Primary Care Network (PCN). These collaborations aim to identify potential projects that can be seamlessly delivered across the Primary Care/Secondary Care interface or within alternative community settings.

Higher Education Collaborations

Warrington and Halton Teaching Hospitals, NHS Trust has scoped opportunities to partner with Higher Education Institutions (HEIs), including Edge Hill, John Moore's and Chester Universities, and through the Applied Research Collaboration Northwest Coast, to develop the academic research portfolio. Collaborations of this nature will enhance opportunities for WHH staff and patients to co-produce research proposals which meet the needs of the local population and secure the necessary funding to undertake that research.

This will enable Warrington and Halton Teaching Hospitals, NHS Trust to apply to competitive funding streams in partnership with other Health and Social Care organisations to secure

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

Local Industry

Sci-Tech Daresbury stands as a flagship organisation for science and innovation and serves as a vibrant hub, blending science, technology, and business to propel innovation and cultivate the growth. It is strategically designed to foster collaboration among businesses, academic institutions, and government organisations, creating a conducive environment for health and technological advancements.

Aligned with WHH organisational objectives, the RD&I Department is actively pursuing a strategic partnership with Sci-Tech Daresbury. Recognising the immense potential of this collaboration, a visit took place in January 2024 marking the commencement of efforts to cultivate a robust and mutually beneficial relationship. This strategic alliance holds the promise of unlocking new avenues for research innovation and growth, further positioning WHH at the forefront of healthcare advancement.

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

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

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

In response to the COVID-19 pandemic, NHS England suspended healthcare contracting and introduced an emergency finance regime. That finance regime included provision for the funding of all Trusts via a "block envelope" paid over to Trusts regardless of activity, performance or quality and included the element identified for CQUIN. However, the CQUIN scheme recommenced in April 2023 and a summary of the progress on the 2023-24 are detailed below.

CQUIN Indicators and Position for 2023/2024								
CQUIN ID	CQUIN Title	Target	Existing or New CQUIN	Financial Incentive	Compliance Quarter 1	Compliance Quarter 2	Compliance Quarter 3	Compliance Quarter 4- Prelim
01	Flu Vaccinations for frontline healthcare workers (annual CQUIN)	Min – 75% Max – 80%	Existing	Yes	N/A	39.08%	51%	51%
02	Supporting patients to drink, eat and mobilise after surgery (documentation) (22/23 CQUIN)	Min – 70% Max - 80%	Existing	Yes	81.82%	91.18%	85.58%	84.33%
03	Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	Min – 60% Max - 40% (NB lower % = more compliant)	New	Yes	28%	21%	14%	9.5%
04	Compliance with timed diagnostic pathways for cancer services	Min - 35% Max - 55%	Existing	No	17.70%	14.04%	11.82%	19%
05	Identification and response to	Min – 10%	New	No	1.93%	6.91%	9.15%	6.92%

CQUIN Indicators and Position for 2023/2024								
CQUIN ID	CQUIN Title	Target	Existing or New CQUIN	Financial Incentive	Compliance Quarter 1	Compliance Quarter 2	Compliance Quarter 3	Compliance Quarter 4- Prelim
	frailty in emergency departments (New)	Max – 30%						
06	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Min – 0.5% Max – 1.5%	Existing	Yes	3.48%	4.89%	Data for November 2023 onwards has not yet been released.	
07	Recording of and appropriate response to NEWS2 score for unplanned critical care admissions	Min – 10% Max - 30%	Existing	Yes	52.5%	75.67%	63.15%	60%
12	Assessment and documentation of pressure ulcer risk	Min – 70% Max – 85%	New	No	44.62%	48.43%	48.58%	47.50%

The following information provides details on the plans for improvements for those CQUINs that have not been achieved in 2023-24.

Plan for Improvement Updates: Non-Financial Incentive CQUIN		
ID	CQUIN Title	Improvement Work Updates
CQUIN 01	Flu Vaccinations for frontline healthcare workers	**Opportunity for Improvement** / **Action Point / Task Required**

Plan for Improvement Updates: Non-Financial Incentive CQUIN

<table>
<tr><th>ID</th><th>CQUIN Title</th><th>Improvement Work Updates</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Reduced appetite amongst healthcare staff to be vaccinated within the Trust. This has also been recognised Nationally</td><td>Communication increased to educate staff and keep the campaign fresh.

The communication plan is dictated by the organisation and therefore improvements cannot be identified to date for 24-25 campaign.</td></tr>
<tr><td></td><td>Visibility increased from the Vaccination Team across both Trust sites and all shifts.

The visibility hours in 2023-24 have been greater than in any other previous campaigns.</td></tr>
<tr><td>Increased patient facing staff identified in the Trust due to using Employment Service Register (ESR) and codes staff roles are identified to on ESR.

This change increased the numbers of patient facing staff although this may not be considered a patient facing role locally. Unfortunately, the measurement system Nationally does not consider local measures and thus impacts on the uptake percentage.</td><td>Discussed with the local ESR team and the flagging system was not altered. To provide a percentage uptake locally the consent form numbers were used to show progression during the campaign.

It is hoped that the campaign 2024-25 will have a clearer definition for “patient Facing Staff” agreed.</td></tr>
</table>
</td></tr>
<tr><td>CQUIN 04</td><td>Compliance with timed diagnostic pathways for cancer services</td><td>
<table>
<tr><th>Opportunity for Improvement</th><th>Action Point / Task Required</th></tr>
<tr><td>Review and evaluation of the revised FIT pathway.

Opportunity to do some improvement work with the Cancer Alliance around the front end of this pathway including review of triage.</td><td>Discussion with Cancer Alliance to take place regrading next steps.</td></tr>
<tr><td>Lung Triage Nurse post to be evaluated against the best</td><td>Recruitment to post.</td></tr>
</table>
</td></tr>
</table>

Plan for Improvement Updates: Non-Financial Incentive CQUIN

<table>
<tr><th>ID</th><th>CQUIN Title</th><th>Improvement Work Updates</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>practise timed pathway 28 Day performance and patient experience.</td><td></td></tr>
<tr><td>Opportunity to improve the pathway for gynaecology cancer patients and also move the service to becoming a cancer unit.</td><td>Recruitment to Gynaecology Clinical Nurse Specialist Post
Pathway Review.</td></tr>
<tr><td>Opportunity to continue improving the prostate pathway for patients with improved compliance against the 28-day standard.</td><td>Evaluation of the Triage Nurse post and business case to continue.
Proposal to go to the Cancer Alliance for an additional Clinical Nurse Specialist.</td></tr>
</table>
</td></tr>
<tr><td>CQUIN 05</td><td>Identification and response to frailty in emergency departments</td><td>
<table>
<tr><th>Opportunity for Improvement</th><th>Action Point / Task Required</th></tr>
<tr><td>To record Clinical Frailty Scale Scores within Same Day Emergency Care</td><td>Face to face meeting 02/02/2024 Dr Nolan working to resolve issues identified – CFS scores not being recorded in SDEC. SDEC
Support being sought from the Associate Medical Director, following meeting February 2024, to resolve barriers to completing CFS scores within SDEC.
Face to face meeting March 2024 Dr Nolan and Chris Barlow with AMD to discuss resolution.</td></tr>
<tr><td>Implement ICE referral process between ED and FAU</td><td>Frailty ICE referrals to go live from Monday 11 March 2024</td></tr>
</table>
</td></tr>
<tr><td>CQUIN 12</td><td>Assessment and documentation of pressure ulcer risk.</td><td>
<table>
<tr><th>Opportunity for Improvement</th><th>Action Point / Task Required</th></tr>
<tr><td>Increase completion of Pressure Ulcer Prevention</td><td>Development of ED specific paper-based pressure ulcer prevention care plan</td></tr>
</table>
</td></tr>
</table>

Plan for Improvement Updates: Non-Financial Incentive CQUIN			
ID	**CQUIN Title**	**Improvement Work Updates**	
		Care Plans within the Emergency Department (ED). Note: ED patients were excluded from the data pull however an opportunity for improvement has been identified.	Monitoring of completion of paper-based care plan during TVN visits to ED
		Improve compliance with Pressure Ulcer – React to Red training.	Promote training and monitor compliance through Operational Patient Safety Group – target 85% Updates: 31 March 2023 – 74.26% 30 June 2023 = 79.17% 30 September 2023 = 81.42% 31 December 2023 = 82.61% 31 March 2024 = 82.12%
		Increase awareness of CQUIN target among ward managers, matrons, lead nurses	Promotion opportunities: • Ward Managers Meeting • Nursing and Midwifery Forum • Operational Patient Safety Group • Within training e.g. Pressure Ulcer Training for Preceptee, newly recruit international nursing staff and other RNs.
		Identification that the Waterlow Risk Assessment links to the Washing and Dressing Care Plan on Lorenzo). Change to data flow required so that the Waterlow Risk Assessment Links to the Pressure Ulcer Prevention Care Plan.	Request and implement change to the agreed dataflow pathway so that the risk assessment links to the care plan.

Plan for Improvement Updates: Non-Financial Incentive CQUIN			
ID	**CQUIN Title**	**Improvement Work Updates**	
		Utilise CPD funding to provide insitu education support to clinical areas to support implementation of evidenced based practice pressure ulcer prevention practice.	Recruit to post to facilitate education support to clinical areas. Report on support provided through OPSG.
		Continue to drive for improvements in pressure ulcer prevention in 2024/25	Pressure Ulcer Task and Finish group is being established to drive forward improvements in pressure ulcer prevention.

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

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

The Care Quality Commission has not taken enforcement action against Warrington and Halton Teaching Hospitals NHS Foundation Trust during 2023-24.

The Trust is registered to provide the following services:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust has not been subject to any special reviews or investigations by the Care Quality Commission during 2023/24.

There was one announced inspection by the CQC in September 2023. The service was inspected as part of the National Maternity Inspection Programme which involves an announced inspection of Maternity Services at each Trust. The CQC continues to rate our maternity services as 'Good'. Following the publication of the CQC report on 17 January 2024, a Maternity Services Improvement Action Plan has been developed to address the 'should do' areas for improvement.

New Service Registered.

New Community Diagnostics Centre at Halton Health Hub opened in December 2023. Patients have been attending for spirometry, phlebotomy and ultrasound appointments and the new Centre now sees approximately 2,000 patients a month.

The Trust offers a Community Spirometry Diagnostic Service (Adults) at Woolston Neighbourhood Hub in September 2023.

The Trust also offers a Community Spirometry Diagnostic Service (Adults) at Padgate Medical Centre (branch surgery) in September 2023.

CQC Engagement.

The Trust was inspected in 2019 where it was rated as 'good'. Warrington and Halton Teaching Hospitals, NHS Foundation Trust has not been inspected during 2022-2023. The CQC have continued their regulatory approach focusing upon CQC engagement meetings which have been held with the Trust throughout the reporting period 2023-24. The CQC have launched a new regulatory model in 2024 using a Single Assessment Framework.

Post CQC Inspection Activity.

The post inspection action plan from the Trust's 2019 CQC inspection was completed in November 2020. Improvements and sustainability are supported and monitored through the Moving to Outstanding Meeting were held monthly by the Chief Nurse, Deputy Chief Executive. This reported into the Quality Assurance Committee which in turn provides assurance to the Trust Board of Directors.

2.10 Information on the Quality of Data.

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

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

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

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

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

2.11 NHS Number and General Medical Practice Code Validity

Warrington and Halton Teaching Hospitals NHS Foundation Trust submitted anonymised clinical data records for patients seen and treated during April – March 2023-24* and 2022-23** to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics which are included in the latest published available data at the time of writing this report. The Trust evidences a positive position when compared with the national average. The final data position report for month 12 was published on 13 May 2024 for the percentage of records and GP Practice Codes.

The percentage of records in the published data which included the Patient's valid NHS Number was as follows:

National Data Set	Trust Valid	National Average Valid	Date Range	A&E Type	Financial Year
Admitted Patient Care *	99.90%	99.70%	Apr 2023 - Mar 2024		2023/24
Outpatient Care *	99.90%	99.70%	Apr 2023 - Mar 2024		
Accident and Emergency (A&E) Care *	99.60%	98.90%	Apr 2023 - Mar 2024	Type 1	
Accident and Emergency (A&E) Care *	99.50%	92.60%	Apr 2023 - Mar 2024	Type 3	
Admitted Patient Care **	99.90%	99.70%	Apr 2022 -Mar 2023		2022/23
Outpatient Care **	100.00%	99.80%	Apr 2022 -Mar 2023		
Accident and Emergency (A&E) Care **	99.30%	98.80%	Apr 2022 -Mar 2023	Type 1	
Accident and Emergency (A&E) Care **	99.50%	86.30%	Apr 2022 -Mar 2023	Type 3	

* Data source provided from SUS – Cumulative year to date to 31/03/2024

** Data source provided from SUS – Cumulative year to date to 13/03/2024

GP Practice Codes

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

National Data Set	Trust Valid	National Average Valid	Date Range	A&E Type	Financial Year
Admitted Patient Care *	100.00%	99.70%	Apr 2023 - Mar 2024		2023/24
Outpatient Care *	100.00%	99.50%	Apr 2023 - Mar 2024		
Accident and Emergency (A&E) Care *	100.00%	99.60%	Apr 2023 - Mar 2024	Type 1	
Accident and Emergency (A&E) Care *	100.00%	97.50%	Apr 2023 - Mar 2024	Type 3	
Admitted Patient Care **	100.00%	99.70%	Apr 2022 -Mar 2023		2022/23
Outpatient Care **	100.00%	99.40%	Apr 2022 -Mar 2023		
Accident and Emergency (A&E) Care **	99.10%	99.10%	Apr 2022 -Mar 2023	Type 1	
Accident and Emergency (A&E) Care **	95.90%	95.90%	Apr 2022 -Mar 2023	Type 3	

* Data source provided from SUS – Cumulative year to date to 31/03/2024

** Data source provided from SUS – Cumulative year to date to 13/03/2024

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

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

2.12 Information Governance Assessment Report 2023-24.

The Trust uses the Data Security and Protection Toolkit (DSPT) 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

(Medical Director). The SIRO (Chief Information Officer) acts as the Trust's lead for information risk. Any areas of weakness in relation to the management of information risk which are identified, or are highlighted by internal audit review, are detailed below.

The Trust's most recent Data Security and Protection Toolkit assessment was finalised by Mersey Internal Audit Agency (MIAA) in August 2023 as part of the Trust's annual audit programme. The Trust was the subject of a two-part Data Security and Protection Toolkit review conducted by MIAA from February to June 2023. Part one of the review concluded that the Trust's self-assessment deviated only minimally from the independent assessment. On that basis the assurance level awarded in relation to the veracity of the self-assessment was substantial assurance.

Part two of the 2023 review conducted by MIAA was comprised of an assessment against the National Data Guardian's 10 data security standards. The assurance level awarded across nine of the data security standards was substantial with one standard rated as moderate. Therefore, the overall assurance level across all 10 National Data Guardian standards was rated as moderate.

The final submission deadline for 2023-24 DSP Toolkit Assessment is scheduled for 30 June 2024 and updates can be accessed via the NHS Digital website: Organisation Search (dsptoolkit.nhs.uk)

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

2.13 Payment by Results (PBR) Clinical Coding Audit.

Warrington and Halton Teaching Hospitals NHS Foundation Trust was not subject to an external clinical coding audit during 2023/24 by the Audit Commission.

Warrington and Halton Teaching Hospitals NHS Foundation Trust have successfully recruited to all vacant clinical coding positions. However, due to a national shortage of experienced clinical coders, vacancies could only be filled with trainees which will take an extended time period to relieve the internal pressures on the team.

Despite the resource issues, Warrington and Halton Teaching Hospitals NHS Foundation Trust continue to support data quality improvements by undertaking the following actions to improve data quality.

- Engagement with clinicians to improve documentation and clinically coded data.
- On-going programme of internal clinical coding staff audits.
- Increased level of support to the Mortality Review Group with documentation and clinical coding reviews.
- Implemented a validation process to review the alert recording and coding of patients with a Learning Disability and/or Autism.
- Support the Trust with external GIRFT deep dives with the national team and internally with reviews and supporting improvement plans.

- Training and updating of skills for trainee and experienced clinical coders.
- Targeted specialty documentation and clinical coding audits.
- Highlight data quality issues for resolution to the Application Support Team.
- Ongoing support for the Mortality Review Group.
- Development of experienced coders in the team to improve staff retention and support a wider quality improvement agenda.

2.14 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 of Directors Meeting. This data must include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, Trusts must estimate how many deaths were judged more likely than not to have been due to problems in care.

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

The Trust currently has 7 trained clinicians who are trained in the Royal College of Physicians Structured Judgment Review (SJR) method for recording deaths, mortality reviews and their outcomes. The Trust has developed an electronic system which logs Structured Judgement Reviews (SJR) electronically and triangulates findings with complaints, claims, inquests, Medical Examiner's Office and clinical incidents. This facilitates richer learning across the Trust.

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

From 1 April 2023 to 31 March 2024, 303 SJRs were completed. 5 investigations (Serious Incidents) were carried out in relation to 1215 of the deaths. They occurred in each quarter of that reporting period as follows:

- Quarter 1 - 93 SJRs completed and 0 Serious Incidents.
- Quarter 2 – 74 SJRs completed and 2 Patient Safety Incident Investigation.
- Quarter 3 - 54 SJRs completed and 1 Patient Safety Incident Investigation.
- Quarter 4 – 82 SJRs completed and 2 Patient Safety Incident Investigation

The Mortality Review Group alongside other modalities provides valuable feedback on all aspects of care and helps us to understand what we may need to improve upon. It also provides the opportunity to identify practice that has been effective and meaningful to our patients. In addition, the Mortality Review Group identify workstreams which ensures the learning is

triangulated and themes identified. The Trust publishes their quarterly and annual Report on Mortality Reviews on the Trust's website: www.www,nhs.uk https://www.www.nhs.net_board-meetings-and-papers

2.15 Reporting Against Mandated Core Quality Indicators - Prescribed Information 2023-24.

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

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

- The national average for the data.
- The NHS Trusts and NHS foundation Trusts with the highest and lowest of the same, for the reporting period.
- Present, in a table format, the percentage/proportion/score/rate/number for at least the last two reporting periods.

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

2.16 Summary Hospital-Level Mortality Indicator (SHMI).

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

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

Date Period	Trust	Banding	England Average	England Highest	England Lowest
November 2022 - October 2023	92.22	2	100.0	120.65	72.15
October 2022 – Sept. 2023	94.68	2	100.0	122.93	67.70
November 2021 - October 2022	97.41	2	99.93	124.70	62.26
November 2020 - October 2021	98.3	2	100.0	118.60	71.90
November 2019- October 2020	106.9	2	100	117.75	67.82
November 2018 - October 2019	106.89	2	100	120.12	68.48
October 2018 – September 2019	105.93	2	100	118.77	69.79
October 2017 – September 2018	109.92	3	100	126.81	69.17
July 2016 – June 2017	112.32	2	100	122.77	72.61
Data Source: Hospital Episode Statistics (HES) data www.digital.nhs.uk/SHMI *The most up to date data on NHS Digital for the period November 2022 - October 2023 published on 14 March 2024 is displayed.					

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

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

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

Trusts are banded 1-3 as follows:

1. The Trust's mortality rate is 'higher than expected'.
2. The Trust's mortality rate is 'as expected'.
3. Where the Trust's mortality rate is 'lower than expected'.

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

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

The Trust continues to share learning from the Mortality Review group using the Mortality and Morbidity (M&M) meetings which are an opportunity for peer review, collective learning and quality improvement. These are held across all 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. In addition, please see section 2.15 on Learning from Deaths.

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

Date Period	Trust	England Average	England Highest	England Lowest
01 November 2022 – 30 October 2023 NB: At the time of writing this report this is the most recent data	49%	42%	66%	16%
01 October 2022 – 30 September 2023	48%	42%	66%	15%
01 November 2021 – 31 October 2022	46%	41%	65%	12%

Date Period	Trust	England Average	England Highest	England Lowest
01 November 2020 – 31 October 2021	55%	40%	64%	11%
01 November 2019- 31 October 2020	45%	36%	59%	8%
01 November 2018 – 31 October 2019	41%	36%	59%	11%
October 2018 – September 2019	40%	36%	59%	12%
October 2017 – September 2018	34.3%	33.4%	59.5%	14.3%
July 2016 – June 2017	41.7%	31.1%	58.6%	11.2%
Data Source: Hospital Episode Statistics (HES) data www.digital.nhs.uk/SHMI *The most up to date data on NHS Digital for the period November 2022 - October 2023 published on 14 March 2014 is displayed.				

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

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

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

- Palliative care coding in the Trust has consistently shown year on year improvement. This reflects increased investment in palliative care services in the organisation alongside increase end of life care education and oversight provided through the Trust's quality structure. This data demonstrates the positive impact of these changes as the increase in palliative care coding reflects improving timely involvement of Palliative Care Services and consideration of palliative care needs at the end of life. Clinical Coding attend Mortality Review Group meetings to ensure that palliative care coding remains appropriate.

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

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

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

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

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

Varicose Veins – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2016/17	100	0.036	0.086
2017/18	78	0.019	0.089
2018/19	The Trust has not had any eligible patients within PROMS since 2017/18 following the transfer of Vascular services to Lancashire Teaching Hospitals NHS Foundation Trust.		
2019/20			
2020/21			
2021/22			
2022/23			
2023/24			

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

PROMs are collected by all providers of NHS funded care. They consist of a series of questions that patients are asked in order to gauge their views of their own health. Patients are asked to score their health before and after surgery. It is then possible to ascertain whether a patient sees a health gain following their surgery. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs HES data. Redevelopment of an updated linkage process between PROMs-HES data is still outstanding for 2022/23 with no definitive date for completion at this present time.

Redevelopment of the linkage processes for PROMS-HES was still outstanding in 2022/23 meaning the PROMs data is not available.

Hip Replacement – Percentage of patients with improvement in EQ-5D health scores		
Year	Trust	National Average
2016/17	0.036	88.2%
2017/18	0.019	89.4%
2018/19	0.500	89.7%
2019/20	0.474	89.4%
2020/21	In order to respond to the challenges posed by the coronavirus pandemic NHS hospitals in England were instructed to suspend all	

Hip Replacement – Percentage of patients with improvement in EQ-5D health scores		
Year	**Trust**	**National Average**
	non-urgent elective surgery for patients for parts of the 2020/21 reporting period. A reduced service continued during the 2021/22 reporting period. This has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMS. In addition, it is possible that behaviours around activities relating to the completion, return and processing of pre and post-operative questionnaires may have also been impacted when compared to earlier years data where behaviours and processes related to managing the current pandemic were not in place.	
April 2021 – March 2022 Finalised PROMs Published: 13 July 2023	0.420	89.8%
April 2022 – March 2023	HES data is provisional for April 2022 - March 23 and will not be finalised for 2022-23 until July 2024 A Trust recovery plan to improve PROMS reporting for 2024-25 has been developed.	
April 2023 -March 2024	HES data is not available for April 2023 - March 2024 PROMs until July 2025	
Data Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms		

Knee Replacement – Percentage of patients with improvement in EQ-5D health scores		
Year	**Trust**	**National Average**
2016/17	0.370	81.0%
2017/18	0.312	82.1%
2018/19	0.324	82.1%
2019/20	0.335	82.8%
2020/21	The Covid-19 Pandemic has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMS. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs HES data.	
April 2021 – March 2022	0.309	87.4%
April 2022 – March 2023	HES data is provisional for April 2022 - March 23 and will not be finalised for 2022-23 until July 2024 A Trust recovery plan to improve PROMS reporting for 2024-25 has been developed.	
April 2023 -March 2024	HES data is not available for April 2023 -March 2024 PROMs until July 2025	
Data Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms		

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

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

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

- A Trust recovery plan to improve PROMS reporting for 2024/25 has been developed, and performance will continually be monitored via the Patient Experience Sub-Committee.

2.19 Emergency readmissions to hospital within 30 days of discharge.

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

Year	Categories	(0 to 15 (%)	16 or over (%)
2018/19	Trust	10.8	13.0
	England Average	12.3	14.3
	England Highest	86.7	68.8
	England Lowest	1.9	2.7
2019/20	Trust	11.7	13.5
	England Average	12.1	14.2
	England Highest	63.5	50.7
	England Lowest	2.6	4.7
2020/21	Trust	11.2	15.3
	England Average	11.6	15.5
	England Highest	89.3	201.1
	England Lowest	4.9	3.4
2021/22	Trust	11.9	12.9
	England Average	12.1	14.1
	England Highest	57.3	167.4
	England Lowest	3.3	2.8

Year	Categories	(0 to 15 (%)	16 or over (%)
2022/23	Trust	11.6	14
	England Average	12.8	15
	England Highest	302.9	922.1
	England Lowest	1.9	1.3
2023/24	*Data not yet published by NHS Digital expected August 2024*		
Data Source: *www. emergency-readmissions*-nhs digital			

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

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

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

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

- A dashboard has been developed and is utilised for greater analysis with clear outcomes identified.
- In 2024/25 this will continue to be monitored at the performance review meetings.

2.20 Responsiveness to the personal needs of patients.

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

Year	Trust	England Average	England Highest	England Lowest
2015/16	71.7	69.6	86.2	58.9
2016/17	69.5	68.1	85.6	60.0
2017/18	*69.6*	*68.6*	*85.0*	*60.5*
2018/19	*66.5*	*67.2*	*85.0*	*58.9*
2019/20	*68.0*	*67.1*	*84.2*	*59.5*
2020/21	*74.3*	*74.5*	*85.4*	*67.3*
2021/22	*76.0*	*67.1*	*84.2*	*59.5*
2022/23	*Following the merger of NHS Digital and NHS England on 1st February 2023 they are reviewing the future presentation of the NHS Outcomes Framework indicators.* *As part of this review, the annual publication which was due to be released in March 2023 has been delayed. Further announcements about this dataset will be made in due course*			
2023/24				
Data Source: NHS Digital Outcomes Framework 4.2 Responsiveness to inpatients' personal needs - NHS Digital				

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

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

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

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

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

The data is made available to the Trust by the National NHS Staff Survey Coordination Centre on behalf of NHS England with regard to the percentage of staff employed by, or under contract to the Trust during the reporting period. This specifies who would recommend the Trust as a provider of care to their family or friends. NHS England took ownership of the NHS Staff Survey, and the indicator was introduced in April 2014. The latest score for the Trust was 61.4%, when compared with other Acute and Acute & Community Trusts, the average median score was 63.3%. It is recognised that the results may be affected by operational challenges and increased patient attendances throughout the financial year however work continues with system partners to improve the position. The Trust has several workstreams in place to enhance performance for staff recommending the Trust as a place for treatment, this includes utilisation of Quality Improvement methodology supported by the Trusts Quality Academy.

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

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

Please note: Figures taken from the Benchmark report are taken from latest available data (2023 survey.)

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

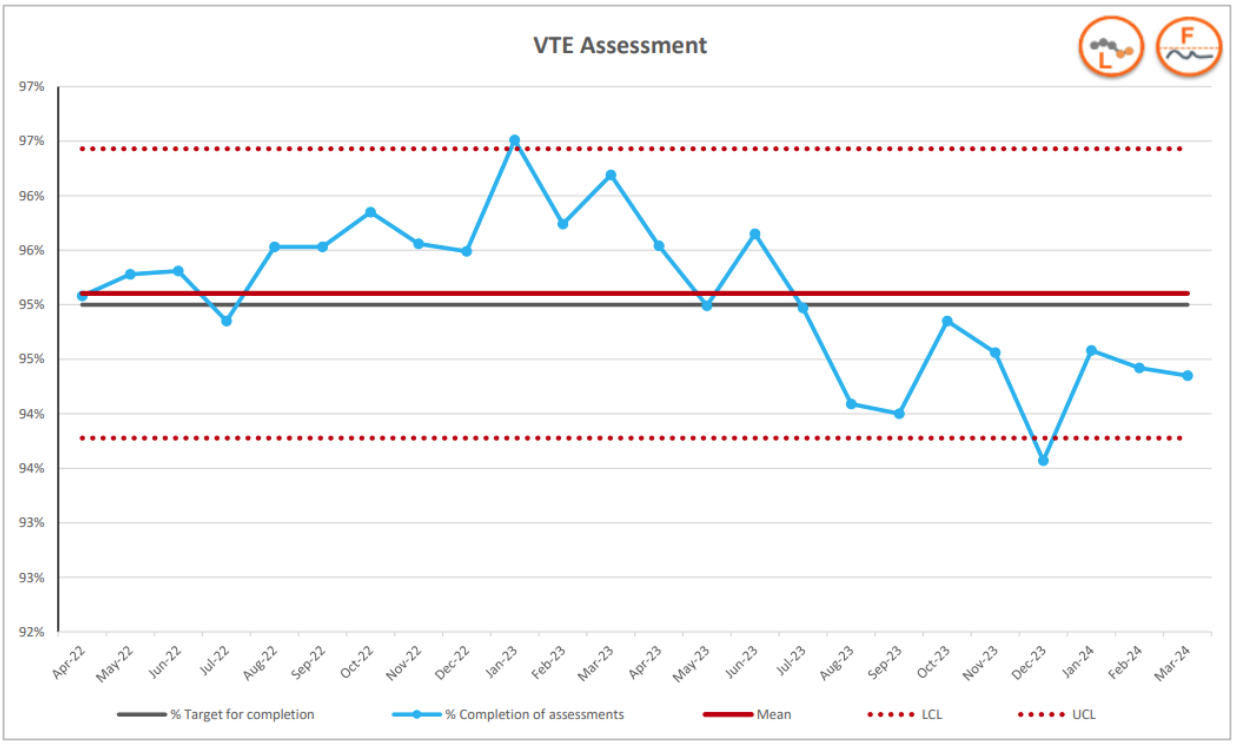
It is also recognised that this report presents the findings of the 2023 national NHS staff survey published on 9 March 2024 which was conducted by Quality Health on behalf of the Trust. Quality Health utilises high quality research methodology and mixed method collection. Results indicate a 45.3% response rate which represents 2049 staff responses.

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

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

Percentage of admitted patients' risk-assessed for Venous Thromboembolism				
Year	Trust	England Average	England Highest	England Lowest
2017/18	94.9%	95.11%	100%	66.44%
2018/19	95.26%	96.0%	100%	74.03%
2019/20	89.36%	96.0%	100%	71.84%
2020/21	*Data collection was suspended in March 2020 so figures for Q4 2020 and onwards are not available*			
2021/22				
2022/23				
2023-24	*The VTE Risk Assessment Data Collection will be reinstated from April 2024, with the first submission due in July 2024.*			

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



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

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

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

- A ward productivity dashboard has been developed by the Trust and now includes VTE risk assessment data at ward level daily for data sharing purpose and for the ownership of this VTE RA data to improve overall compliance. This has been launched Trust wide in December 2023.
- The Trust continues to raise awareness of the need for VTE completion at the new August intake induction and with every changeover of junior doctors 4 months placement.

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

The data made available to the Trust by the UK Health Security Agency with regard to the rate per 100,000 bed days of cases of Clostridium Difficile infection (CDI) reported within the Trust amongst patients aged 2 or over during the reporting period. The published data now includes the statistics for the Trust apportioned cases of CDI. It has been recognised that Clostridium Difficile Infection has increased as a likely consequence of antibiotic prescribing for respiratory infections during the pandemic.

Rate per 100,000 bed days of cases of Clostridium Difficile Infection (CDI) (Trust apportioned cases)				
Year	**Trust** Rate	**England Average for Acute Trusts**	**England Highest for Acute Trusts**	**England Lowest for Acute Trusts**
2023/2024	The data published by **UK Health Security Agency** (UKHSA), formerly Public Health England) will be updated at the end of September 2024 when the latest national data is available.			
2022/2023	41.6	43.58	133.6	0.0
2021/2022	39.5	43.92	138.4	0.0
2020/2021	42.3	45.67	140.5	0.0
https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data Annual publication of epi commentary (publishing.service.gov.uk)				

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

- There is a robust system for data entry and validation which ensures that all cases are entered onto the UK Health Security Agency Capture Data System.

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

- This is monitored monthly on the Trust Integrated Performance Report, reported to Infection Control Sub-Committee, Quality Assurance Committee, the Trust Board and the Integrated Care Board.
- Investigations to support learning are robust and undertaken accordingly.
- There are action plans in place to prevent Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia, Clostridium Difficile and Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia cases, CDI and Gram-negative bloodstream infections (GNBSI)
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment.
- Action plan is in place to prevent Gram-Negative Blood-Stream Infections (GNBSI).

2.24 Patient Safety Incidents.

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

Patient Safety Incidents – Rate of incidents per 1000 bed days					
Period	**Trust**	**Trust Number**	**England Median**	**England Highest**	**England Lowest**
April 2023 – March 2024	In September 2023 NHS England paused the annual publishing of this data while they consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the National Reporting and Learning System (NRLS). Data is now published annually by NHS England so this data will not be available until later in 2024. Confirmation of a date is awaited. Prior to the 29 September 2021 data, these official statistics were published every six months.				
April 2022 – March 2023					
April 2021 – March 2022 NB This is the latest reporting data	35.72	6468	57.5	205.52	23.67
April 2020-March 2021	51.0	8089	58.4	118.7	27.2
Oct 2019 – Mar 2020	44.3	4045	50.7	110.2	15.7
April 2019 – Sept. 2019	48.69	4272	48.5	103.8	26.3

Patient Safety Incidents – Rate of incidents per 1000 bed days					
Period	**Trust**	**Trust Number**	**England Median**	**England Highest**	**England Lowest**
Oct 2018 – Mar 2019	44.68	3964	44.5	95.94	16.9
April 2018 – Sept. 2018	41.6	3833	42.4	107.4	13.1
Oct 2017 – Mar 2018	38.78	3764	42.55	124	24.19
April 2017 – Sept. 2017	41.07	3619	42.84	111.69	23.47
Data is now published annually by NHSE so this data will not be available until later in 2024					
NB: NRLS Report provided median rate of incidents per 1000 bed days reported by all non-specialist acute Trusts, however, *The NRLS discontinued the use of the large Acute Trust cohort at its publication in April 2015.*					

Patient Safety Incidents Resulting in Severe Harm or Death				
Period	**Trust**	**England National**	**England Highest**	**England Lowest**
Severe Harm and Death April 2023– March 2024	In September 2023 NHS England paused the annual publishing of this data while they consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the National Reporting and Learning System (NRLS).			
Severe Harm and Death April 2022– March 2023				
Severe Harm and Death April 2021– March 2022 NB This is the latest reporting data	0.1% (12)	0.2% (Non-specialist acutes only)	0.9% (120)	0% (3)
Severe Harm and Death April 2020 – Mar. 2021	0.1% (16)	0.2% (Non-specialist acutes only)	1.4% (163)	0% (5)
Severe Harm and Death Oct 2019 – Mar 2019	0.2% (9)	0.3% (Non-specialist acutes only)	1.5 (19)	0 (0)
Severe Harm and Death April 2019 – Sept. 2019	0.44% (19)	0.3% (Non-specialist acutes only)	1.6 (58)	0% (0)
Severe Harm and Death Oct 2018 – Mar 2019	0.45% (18)	0.3% (Non-specialist acutes only)	1.8 (42)	0.009% (1)
Severe Harm and Death April 2018 – Sept. 2018	0.73% (28)	0.3% (Non-specialist acutes only)	1.2 (48)	0% (0)
Severe Harm and Death Oct 2017 – Mar 2018	0.37% (14)	0.3% (Non-specialist acutes only)	1.55% (99)	0% (0)
Severe Harm and Death April 2017 – Sept. 2017	0.64% (23)	0.4% (Non-specialist acutes only)	1.98% (121)	0% (0)
Data is now published annually by NHSE so this data will not be available until later in 2024				

Patient Safety Incidents Resulting in Severe Harm or Death				
Period	**Trust**	**England National**	**England Highest**	**England Lowest**
NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same Trusts. NB - *National = Severe Harm and Death combined. **NB: NRLS Report provided median rate of incidents per 1000 bed days reported by all non-specialist acute Trusts, however, *The NRLS discontinued the use of the large Acute Trust cohort at its publication in April 2015.***				

Whilst data for the reporting period has not been received as a benchmark comparator at the time of writing this report, Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- That it downloads all incidents via DATIX to the National Reporting and Learning System within the agreed timescales where the data is derived. This system will be replaced in 2023/2024 nationally.

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 which actively encourages incident reporting by all members of staff promoting an open and honest culture.
- Continue to undertake investigations at the appropriate level dependent upon the severity of the clinical incident reported.
- Continue training for staff to use the Trust online reporting system, Datix.
- Continue to support for senior staff with risk training to assist them when reviewing incidents.
- Continue to obtain assurance with regard to the monitoring of actions from incidents to ensure that they are completed in a timely manner.
- Additional scrutiny continues at the Trust Safety Oversight Group led by the Chief Nurse, Deputy Chief Executive.
- The Trust also has in place a Clinical Harm Review Panel to support waiting list management.
- An incident overview is provided weekly to the Executive Team.

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

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

- 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.

2.25 Friends and Family Test Data.

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

2.26 Freedom to Speak Up (FTSU)

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

In February 2024 following a recruitment process the Trust appointed a new FTSU Guardian and Deputy Guardian, each working 2 and 1 day per week respectively. The Trust also has a named FTSU Executive Lead and Non-Executive Lead. In addition, there are over 35 FTSU Champions from across the Trust representing different backgrounds and professions. Further champions are being recruited to look to further strengthen representation from across the organisation. Staff within the Trust can speak up directly to the Guardian/Deputy Guardian or a Champion; they can text/phone/WhatsApp voice message, email or write to the 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/teams meeting or the opportunity to discuss further on the phone. The FTSU team will highlight the purpose of the process and advise on what they can do next, the person raising the issue is then supported by FTSU in whatever action they decide to take. The individual can remain anonymous if they wish and we discuss if this is possible and the impact.

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

The Trust FTSU team completed quarterly national return on activity and reports to the Trust Board twice a year and the Strategic People Committee quarterly. The data in the table below

shows the number of disclosures raised using the Freedom To Speak Up (FTSU) Team and noted reported increase in disclosures in 2022/23 compared to 2022/22.

FTSU Disclosures			
Quarter	**2021/22**	**2022/23**	**2023/24**
Quarter 1	4	17	6
Quarter 2	8	5	6
Quarter 3	6	13	9
Quarter 4	2	7	10
Total	**20**	**42**	**31**

*Quarter 4 data not available as incomplete as of reporting

The types of disclosure cases have been grouped and are detailed in the table below:

FTSU - Types of Disclosures			
Types	**2021/22 Q1 – Q4**	**2022/23 Q1 – Q4**	**2023/24 Q1 – Q4**
Behaviour, culture and relationships	15	32	18
Process	2	3	1
Patient safety	1	5	1
Staff levels / patient care	2	1	1
Communication	0	1	0
Total	**20**	**42**	**21**

The number of disclosures is benchmarked against similar Trusts and national guidance is reviewed and implemented. The Trust has recently undertaken the national toolkit provided by the office of the national Guardian.

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

2.27 Seven Day Hospital Services (7DS).

The Trust is committed to achieving the standards and continues to implement the priority clinical standards for seven-day hospital services.

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

Paediatrics.

In 2022, Paediatrics achieved the required 86% compliance with the standard. The compliance was again audited in 2023 with shown a 100% compliance rate was achieved.

The project reviewed emergency paediatric admissions to hospital and the audit was completed in March 2022 showing, 77 patients were identified with 34 being discharged from PAU and 43 being admitted overnight. Out of the 77 patients, 41 required a consultant review and 2 were identified as low complexity. 35 patients were reviewed within the 14 hours and 6 were not, resulting in 86% compliance.

Following the review in 2023, 85 patients were identified with 26 being discharged from PAU and 59 being admitted overnight. Out of the 85 patients, 44 required Consultant review and 15 were identified as low complexity. 44 patients were reviewed within the 14 hours and 6 were not, resulting in 100% compliance.

The key findings of the audit are noted below. These include:

- Despite a higher number of admissions, there were no patients who missed the 14-hour consultant review target (when required).
- A greater number of admissions were able to be deemed “low complexity”, and thus did not require consultant review.
- A SOP was updated after the 2022 audit to better define which patients can be allocated into the ‘low complexity’ category.
- 15 patients were identified as “low complexity” this in 2023, as compared to only 2 on last year’s audit.
- The period of the data collection has some overlap with doctor’s strike.
- Results benefited by having more senior registrars on the rota.
- As per the SOP, Paediatric ST7+ / SAS doctors constitute a consultant review.
- 5/44 patients requiring consultant review were seen by ST7+/SAS doctors.
- Results greatly benefited from having a paediatric consultant in ED.
- As per the SOP, patients reviewed by the consultant (or Paediatric ST7+ / SAS doctor) in the Emergency Department do not require a consultant review on the ward.

A re-audit has been scheduled to be undertaken in 2024-25 in to test improvements and demonstrate improved compliance with the standard.

General Surgery

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

For General surgery 2/33 patients had no Consultant review time recorded and were therefore identified as outside the 14-hour standard.

The findings from this re-audit demonstrated that the General Surgical team remains compliant to a high standard with the 7-Day Services Clinical Standard 2: Time to consultant review within 14 hours. This demonstrates that they have maintained improvement in compliance consistently above 90% since February 2022 to November 2022 with 96% and 94% compliance respectively, from the initial 77% compliance in July 2021.

This High level of compliance has been supported by the implementation of the delegated review Standard Operating Procedure and following education, learning, and sharing opportunities following the 1st cycle. The twice daily consultant post take ward round, increased IT provision with Laptops being provided for the On-Call team, and the increased awareness of surgical referrals from the Emergency Department have significantly contributed to this position.

Lastly, this audit demonstrated that 55% of documentation included time of consultant review within the clinical notes, rather than relying on the time stamp of the document automatically generated by Lorenzo. This has highlighted that compliance could be further improved if the time of the consultant review is documented in real time, every time. The 1st Cycle highlighted this challenge detailing 11% compliance, the 2nd Cycle demonstrated 54% compliance, lastly the 3rd Cycle demonstrated an increase to 55%. This is area continues to require improvement for which plans are in place.

The key findings of the audit and areas for improvement have been actioned through Foundation teaching. This information has also been delivered at the Corporate Induction to both Foundation Year 1 and Foundation Year 2 doctors and presented at the Surgical Induction so that new doctors are reminded to document the time of the consultant review and that this is clearly recorded in the clinical notes, particularly as some entries are written retrospectively and that this can skew the correct timelines due to automated timestamp on Lorenzo.

Both teams recognise the importance of achieving timely consultant review and have evaluated the audit and implemented action plans. A focus on 7 Day Services continues.

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

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

We continue to recruit to doctors in training across the Unplanned Care Group which at the time of reporting has two gaps. These gaps consist of GPST/IMT and registrar posts.

In the short to medium term, rota gaps are covered through use of Trust Bank doctors and some Agency doctors. We are in the process of advertising fixed term posts through NHS jobs.

The table below shows the Deanery Trainee gaps on 31 March 2024:

Deanery Trainee gaps		
Care Group	**Grade**	**Number of Deanery Trainee Vacancies**
Planned Care	IMT Gaps	0 (1 IMT2 on maternity leave but is back 05.05.24)
	GPST Gaps	2 in Obstetrics & Gynaecology
	Reg Gaps	1 in Radiology
	Specialist Trainee	1 in Otolaryngology
	Specialist Trainee	1 ST Paediatrics (Trust funded)
	Specialist Trainee	1 ST Surgery (long term sick)
	Reg Gaps - Maternity / Paternity leave GAPs	1 x ST Gastroenterology
		2 ST Surgery
	GPST - Maternity / Paternity leave GAPs	1 x Obstetrics & Gynaecology
Unplanned Care	IMT Gaps	0
	GPST	5 x General Internal Medicine
		5 x Emergency Medicine
		2 x Acute Internal Medicine
	Reg Gaps	1 x Emergency Department
		Acute Internal Medicine x 1 from June to August 2024
Clinical Support Services	GP Specialty Training	0

The rota gaps are presented and discussed at the Medical Education Quality Committee and at the Junior Doctors Forum.

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

Medical Rota Infrastructure:

- Early identification of gaps from deanery data.
- Implementation of e-rostering for junior doctors.
- Consolidation of speciality rotas into a single rota by grade/tier to allow an effective spread of available junior doctor resource.

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

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

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

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

- International Fellows (ITFs) – The Trust actively participates in this scheme designed to allow doctors to enter the UK from overseas in order that they can benefit from training and development in NHS services before returning to their home countries. We continue to recruit through this programme where appropriate.

- Exploration of alterations to doctor in training on call rotas to maintain service requirement and reduce frequency of gaps:
    - Physician Associates (Pas) –The Trusts has a well-established a Physician Associate workforce and training program delivered through the University of Chester. This allowing alternative and sustainable skill mix within departments working alongside doctors in training on on-call rotas.

    - Advanced Clinical Practitioners (ACPs) and Trainee Advanced Clinical Practitioners (TACPs)

    - We have been successful in recruiting ACPs and TACPs across the organisation. Supporting these roles through gaining a master's degree in advanced clinical practice from a Higher Education Institute (HEI). Offering work based and academic learning. These roles work towards developing the clinical skills to provide care autonomously following completion of the trainee position. Allowing us to establish a workforce that can work alongside our doctors in training and further support out of hours working once qualified.

Part 3

Our Quality Improvements and Progress against other Quality Indicators

3.0 Our Quality Improvements and Progress against other Quality Indicators

This section details:

- **A summary of the quality priorities agreed for 2024-25.**
- **Details on the Trust's performance on a range of other relevant quality performance indicators and thresholds which have been extracted from NHS nationally mandated indicators and locally determined measures.**
- **Detailed information and commentary on a selected range of improvement areas relating to the three domains of quality: Improve Patient Safety, Improve Clinical Effectiveness and Improve Patient Experience.**

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

3.1 Quality Priorities 2024-25.

Our quality priorities chosen for 2024-25 align to the three domains of quality with the Trust. These are detailed below:

The improvement aims	Description of Quality Priorities	The outcome
Improve patient safety	1. Ensure that all patients within the Emergency Department receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes 2. Reduce elective long waits by having no patients waiting > 6 weeks for a diagnostic test and improve performance 3. Reduce the number of category 2 pressure ulcers by 20% with zero tolerance of category 3 and category 4 pressure ulcers	**Patient safety is enhanced through a learning culture where quality and safety is everyone's top priority**
Improve clinical effectiveness	4. Improve the safety culture in theatres with focus on consistency, psychological safety; and learning, evidenced through 95% compliance with safe surgery standards aiming for no procedural Never Events in theatres 5. Continue the GIRFT programme delivering the Trust's GIRFT objectives in each of the Care Groups to deliver more timely and effective patient care 6. Continue to embed Patient Safety Incident Response Framework by developing organisational culture programme and learning system across the Trust	**Practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients**
Improve patient experience	7. Ensure that there are robust frameworks in place to care for patients with mental health challenges, evidenced through the implementation of a training package for nursing and medical staff and 95% compliance with the completion of Mental Health Act assessment and detention documentation 8. Improve discharge processes to support clinical demand and safe patient care, evidenced through a maximum of 15% bed occupancy in the number of patients with no right to reside, averaged over 12 months 9. Ensure 95% compliance in the completion of assessments relating to nutrition and hydration with assurance of appropriate action undertaken to improve clinical outcomes	**The quality of the patient experience is at the heart of all we do and 'seeing the person in the patient' is the norm**

3.2 Data Sources.

The Trust compiled a list of potential quality improvement priorities for 2024-25 by:

- Evaluating performance against the quality and safety priorities for 2023-24.
- Evaluating performance against the quality improvement projects undertaken by the Trust.
- Consideration of national and local priorities - agreed with the Integrated Care Board.
- Consideration of regulation priorities and Care Quality Commission fundamental standards.
- Areas identified as requiring improvement.

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

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

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

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

3.3 Quality Dashboard.

The clinical indicators in the Quality Dashboard 2023-24 have been reviewed in line with the revised requirements for 2024/25 in relation to the following:

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

This is part of a wider review of quality to align reporting with the committee structure under safety; effectiveness and experience, reporting to the Quality Assurance Committee. The information on this Quality Dashboard is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and improvements are maintained.

Since April 2016 the Board has received an integrated performance dashboard which triangulates quality, access and performance, workforce, and financial information.

3.4 Quality Indicators – rationale for inclusion.

The following section provides an overview of the quality of care offered by the Trust based on performance in 2023-24 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.

Please note where any of these quality indicators for 2023-24 have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they will not be repeated here; only the additional indicators which have not already been reported in Part 2 will be reported here to avoid duplication of reporting.

3.5 Performance against key national indicators.

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

https://www. risk-assessment-framework-and-reporting-manual-for-independent-sector-providers-of-nhs-services

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

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

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

The NHS Outcomes Framework (NOF) is under review and is part of a wider consultation on statistical outputs which was released on 12 December 2023. As part of the consultation, it is proposed that only a limited number of NOF indicators will still be published by NHS England on an annual basis. While the consultation takes place, NHSE are intending to release data for indicators that are proposed to continue in the near future, as availability of source data allows. Following the results from the consultation, NHSE will review the future presentation of the NHS Outcomes Framework indicators.

3.6 Performance against the relevant indicators and performance thresholds.

The Trust aims to meet all national indicators and minimum standards including those set out within the NHS Improvement indicators framework. Performance against the relevant indicators and performance thresholds against national priorities can be accessed via the following link IPR Report WHH Trust Board Part 1 Papers - 7 February 2024 v5.pdf which details the Integrated Performance Report (IPR) and Assurance Committee Reports; which are monitored on a monthly basis at the Public Board of Directors meetings Part 1.

The Integrated Performance Report includes 81 IPR indicators. The Trust Board monitors all 81 IPR indicators which have been placed into one of several "Assurance" categories and one of several "Variation" categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count. The Integrated Performance Report and Dashboard has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

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

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

3.7 National Survey Results.

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

The National Survey results help us to ensure we direct our improvement efforts towards actions that will have the greatest impact on patients' experience of care and treatment. While clearly there will be standalone 'quick win' actions to take, equally important are the opportunities influence our transformation and improvement initiatives by encouraging them to take on board insight that the national inpatient survey offers us.

You can view our latest National Survey results here:
https://www.cqc.org.uk/provider/RWW/surveys

- 2022 Adult Inpatient Survey results were published September 2023 Adult inpatient survey 2022
- 2022 Urgent and Emergency Care Survey results were published July 2023 Urgent and emergency care survey 2022
- 2023 Maternity Survey results were published February 2024 Maternity survey 2023

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

2023 Surveys

- **2023 Adult Inpatient Survey:** fieldwork January – April 2024, publication August 2024 (TBC)
- **2023 Children and Young People Survey**: fieldwork August- November 2023, publication April 2024 (TBC)

2024 surveys

- **2024 Children and Young People:** fieldwork July – October 2024, publication March 2025 (TBC)
- **2024 Urgent and Emergency Care:** fieldwork April – July 2024, publication October 2024 (TBC)
- **2024 Community Mental Health:** fieldwork August – November 2024, publication March 2025 (TBC)
- **2024 Maternity:** fieldwork April – June 2024, publication December 2024 (TBC)
- **2024 Adult Inpatients:** fieldwork January – April 2025, publication August 2025 (TBC)

3.8 Friends and Family.

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

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

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.

The Trust has in place an FFT contract in order to improve the process and increase the response rate for example, through text services.

Friends and Family scores:

Inpatient wards and day case plus Emergency Department:

Users are asked to rate their responses and the results of positive experiences for 2023-24 are detailed in the table below:

The Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- Continuing to listen to and act on all sources of feedback to review our services from the patients' perspective and enable us to drive improvements in care.

Month	Inpatient 2019/20	Inpatient 2020/21	Inpatient 2021/22	Inpatient 2022/23	Inpatient 2023/23	A&E 2019/20	A&E 2020/21	A&E 2021/22	A&E 2022/23	A&E 2023/24
Apr	95%	FFT was Paused due to the COVID-19 pandemic, therefore no data was available for the period Mar 2019-Dec 2021	98%	98%	97%	82%	94%	79%	68%	81%
May	96%		98%	97%	98%	84%	91%	78%	72%	80%
Jun	96%		98%	97%	98%	82%	89%	77%	70%	72%
Jul	94%		96%	97%	97%	82%	89%	73%	70%	75%
Aug	95%		96%	96%	98%	83%	84%	70%	72%	79%
Sept	96%		97%	97%	96%	78%	87%	72%	72%	78%
Oct	95%		96%	97%	98%	78%	81%	68%	74%	77%
Nov	96%		98%	96%	97%	77%	86%	73%	71%	76%
Dec	96%		97%	95%	97%	78%	93%	75%	66%	73%
Jan	95%	98%	98%	98%	97%	81%	93%	75%	84%	76%
Feb	95%	94%	97%	97%	97%	81%	86%	71%	78%	71%
Mar	FFT Paused	97%	98%	96%	97%	FFT Paused	79%	66%	75%	75%

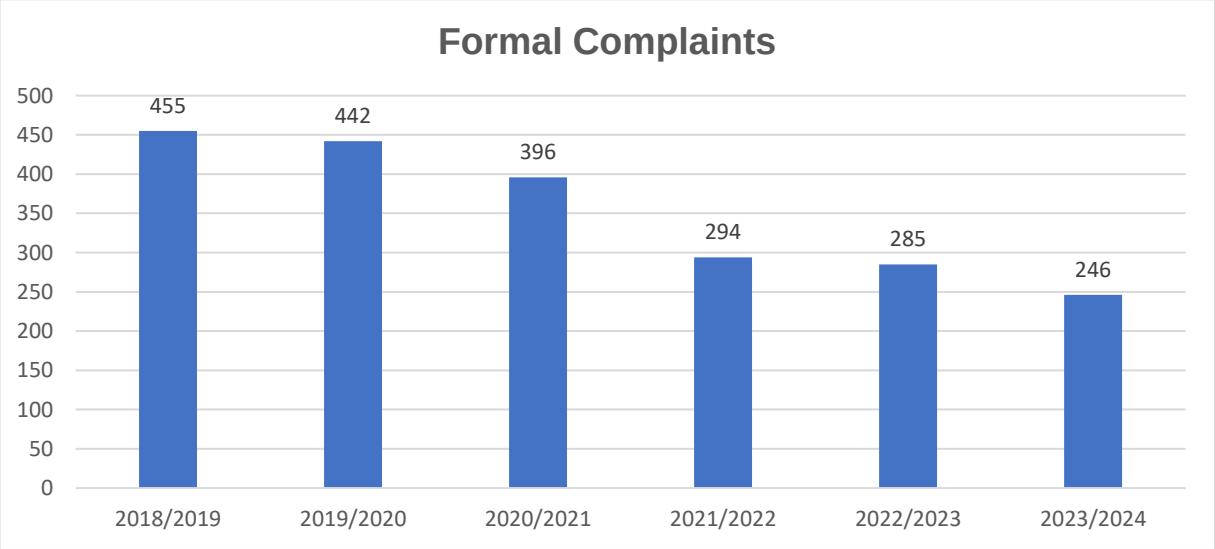
Data Source: The ratings are published on both NHS Choices and in the Open and Honest publication which is published on the NHS England Trust websites.

3.9 Complaints.

The Trust continue to have a key focus upon the management of complaints and a positive position has been sustained pre-dating the reporting period. This is a key achievement for the Trust. The number of formal complaints continue to be reduced with many cases being addressed through the Patient Advice and Liaison Service. This is a positive position for patients and their families ensuring efficient resolve to any concerns. Meetings in person are also offered to all patients or families that may wish to raise a complaint. It is through this mechanism that the greatest learning and improvement is achieved.

The table below details the number of complaints received within the Trust over the year 2023-24. The data demonstrates that the Trust has continued to reduce the number of complaints year on year from 285 complaints received in 2022-23 compared to 246 complaints received in 2023-24.

The reduction in complaints is largely attributed to the commitment from each of the Clinical Business Units (CBU's) who are promptly reviewing and engaging with each of the specialities designated complaints handler, which has helped focus on the quality of responses provided. The positive relationship between the team and the CBUS's is evidenced in the significant reduction of complaints received in the last 5 years.



3.10 Parliamentary and Health Service Ombudsman (PHSO).

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

Complainants dissatisfied with the Trust's response have the right to ask the PHSO to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

The PHSO will consider the complaint file, medical records, and any other relevant information as necessary. The PHSO may decide not to investigate further, and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to

consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and/or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

The table below details the progress of cases received within the Trust over the year 2023-24. In the year 2022/23 the total number of PHSO cases closed was 6, where 3 were partially upheld and 3 were not upheld. In the year 2023/24 a total of 2 PHSO cases were closed, where only 1 was partially upheld and the other was not upheld.

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

Content	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
PHSO cases received	0	0	0	0	0	0	0	2	1	0	0	0	1	0	1	0	0	0	0	0	1	4	1	0
PHSO cases closed	0	0	0	1	0	0	0	1	0	2	0	2	0	0	0	0	0	0	0	0	1	0	0	0
Ongoing PHSO Cases at the end of 2023-24 = 7 Cases																								

3.11 Patient Stories.

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

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

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

- Continuing monthly d/Deaf awareness training sessions, running until March 2024, open to all Trust colleagues.
- Including the d/Deaf Community in EDS Engagement Events to reflect on services provided.
- Initiation of visual alert on patient paper notes and patient bedside to highlight communication support required.
- Focused meetings and ward visits to ensure compliance with the interpretation policy.
- Monthly meeting with Patient Experience and Inclusion, Deputy Chief Nurse and Deaf Advocacy Groups and contracted Interpretation Services

Updated visiting times, including:

- Revision of visiting times and launched in November.
- Communications to advise of guideline for visiting.
- Introduction of children visiting wards

Addressing comments around communal areas by:

- The Launch in September 2023 of First Impression observational rounds in communal areas continue. Represented by Patient Experience and Inclusion, Volunteer Team, Governors, Estates and Facilities.
- Initial focus on welcoming areas, keeping areas clutter free and tidy, with clear signage in place.
- Actions noted and will be reported through Patient Experience Sub Committee for updates.

3.12 Patient Safety Incidents.

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

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

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

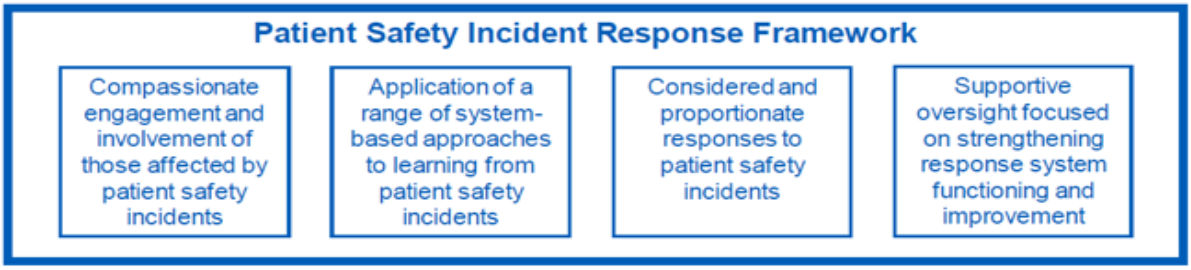
A total number of 10396 patient safety incidents were reported in 2023/24, a decrease on the previous financial year which had 12521 reported patient safety incidents. Within this figure 38

serious incidents and patient safety incident investigations were reported. These equate to 0.4% of the overall figure. 83% relate to incidents with no harm caused and 15% relate to low harm. 1.6% of incidents resulted in moderate harm. The Trust is 100% compliant with all duty of candour responsibilities. A quarterly 'Learning from Experience' report is discussed via the Quality Assurance Committee to detail the incident reporting position and associated learning.

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

The PSIRF was adopted on the 1 September 2023 it is mandated for any organisation who provide funded NHS care, and currently approximately 50% of organisations across the NHS have gone live. The PSIRF Policy and plan are available on the Trust's website and are based on the national template.

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



Via the PSIRF Task and Finish Group and the PSIRF Executive Oversight Group the implementation schedule has been worked through to ensure that appropriate plans and processes are in place to achieve successful implementation.

The various tools, and types of investigations and reviews that can be used for learning and improving patient safety include:

- Patient Safety Incident Investigation (PSII) – in-depth review of a single or cluster of incidents to understand what happened and how.
- Multidisciplinary Team Review – aims to through open discussion to agree the key contributory factors and system gaps that impact on safe patient care.
- Swarm Huddle – initiated as soon as possible after an event and involves and MDT discussion. Staff 'swarm' to the site to gather information about what happened and why and decide what needs to be done to reduce reoccurrence.

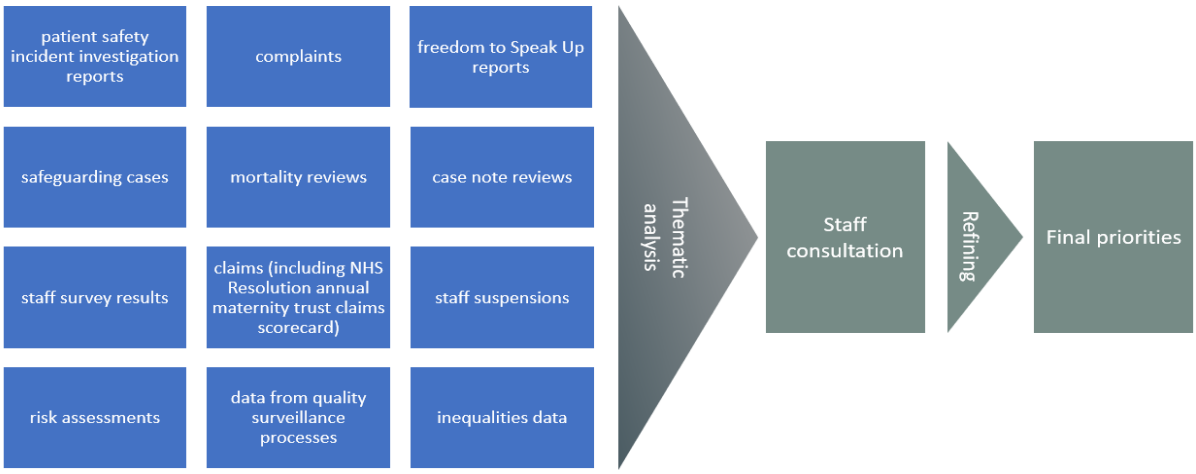
- After Action Review (ARR) – structured facilitated discussion of an event, based around four questions.

WHH has been using the new learning response methodologies (to support incident investigations) and confidence is growing with the different approaches. These are supporting compassionate engagement with patients, families and staff through direct contact and involvement where appropriate. This approach also enables a proportionate response to safety events.

The development of Local Priorities has taken place following extensive review of WHH data in order to identify issues which have been enduring and impact across a range of data sources in order to ensure opportunities for triangulation and maximise learning opportunities.

This exercise has resulted in the development of 3 local priorities which will be investigated using PSII methodology.

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



**Process adopted for developing WHH local priorities.*

Training is being provided to staff to support the PSIRF requirements, and the Patient Safety Training Syllabus has been mandated and is available through the Electronic Staff Record. The Trust Board of Directors have participated in oversight training to support their roles in safety. In addition, Human Factors training has been provided to staff who are undertaking any safety or learning activities.

The following information provides an overview of the current position:

- Both PSIRF and Learn From Patient Safety Events (LFPSE) went live on the 1 September 2023
- PSIRF Policy and Plan are live on WHH internet site.
- LFPSE embedding.
- Confidence growing with new tools and techniques to support learning responses (formally investigations)

- Governance processes embedding, oversight via Executive PSIRF Group
- Mandated Patient Safety Syllabus training figures improving monthly. Level 1 at 92.5%, Level 2 at 75% and Senior Leaders at 95%.
- Two Patient Safety Partners in post and settling into new roles.
- Additional Patient Safety Specialists appointed now 7 in post all undertaking new Safety Syllabus training level 3 and 4.

The following information provides an example of how the Trust has managed a Paediatric Audiology incident well and applied the PSIRF principles.

- On the 19 April 2024, the Care Quality Commission Medical Director sent a letter to all Trusts who provided Paediatric Audiology services
- The letter explained the problems that had been identified with hearing services across the NHS and the impact on children affected
- The letter requested that all Trust Boards review the issues outlined in the letter and provide an update on progress towards UKAS Improving Quality in Physiological Services (IQIPS) accreditation scheme by the 30 June 2024
- As WHH were one of the sites originally identified as having low yield for Paediatric Childhood Hearing Impairment, significant progress, improvement and reporting has already been achieved
- Work has continued to progress with the implementation of the local improvement plan and the final report regarding progress and improvement into Paediatric Audiology Services was reported to the Quality Assurance Committee on the 12 March 2024 and to the Trust Board on 3 April 2024 (with 6 monthly updates requested)
- WHH have recruited a project manager to support the IQIPS accreditation process with UKAS – and a benchmark assessment was undertaken on the 9 and 10 January 2024
- An action plan to drive improvements is in place and actions are being implemented within the service

Summary of learning from the Paediatric Audiology incident

- The Audiology team remain engaged and supportive and are driving the local improvement plan
- Independent Auditory Brainstem Response (ABR) practice has been recommenced at WHH
- Peer review of ABR traces were in place with Children and Maternity (C&M) peer review team
- Mutual aid concluded on 31/10/2023
- Service and Incident review full report was submitted to the Trust Board in February 2024.
- PLACE pathway review recommends ongoing support of the current model of practice.
- Joint WHH & BW audiology team organisational development sessions held on 18 January 2024 and 23 April 2024
- Ongoing monitoring of the 8 remaining children is in place and an approach has been agreed on a case-by-case basis by PLACE
- Final check review from the Safeguarding team regarding the perspective of those children that were not brought to the clinic to be reviewed
- Proactive case reviews have been undertaken and recall of patients where necessary
- Communication with families and other stakeholders

3.13 Duty of Candour.

The Care Quality Commission (CQC) introduced the Duty of Candour regulation in November 2015. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. - Requirements include informing people about the

incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

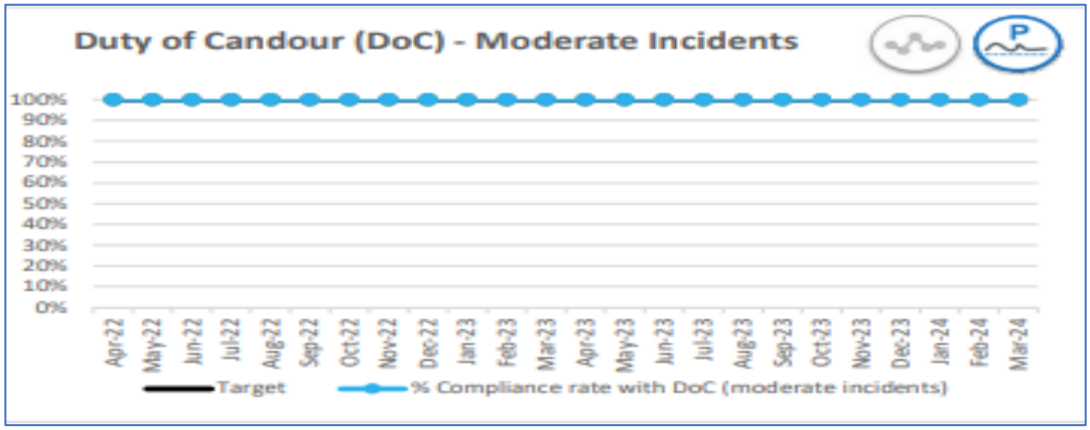
The Duty of Candour requires the provision of an apology, both verbal and written and feedback to the person affected, detailing the findings of the investigation and what actions are to be taken to avoid future occurrences of a similar nature. If an incident is entered as moderate or above the harm level should be validated within 10 working days. This is in line with the regulatory requirement. If after this period the harm level is confirmed, or still unclear, Duty of Candour must be completed. Each element of the Duty of Candour compliance is monitored for verbal and written apologies followed by written feedback provided following completion of investigations.

The Trust monitors Duty of Candour at the weekly Serious Incident Meeting held by the Clinical Governance Team, chaired by the Associate Director of Governance. 100% Compliance with Duty of Candour is consistently achieved. This 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 Learning Response, a patient or family liaison officer continues to be appointed to provide support and advice. A stand-alone Duty of Candour Policy to support staff with the delivery of Duty of Candour to patients/families of those who have sadly been involved in an incident, resulting in harm has been ratified.

In 2023-24, Duty of Candour was applied to 103 incidents. This is a decrease on last year's figure as detailed in the table below.

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

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



3.14 Compliance for Patient Safety Alerts.

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

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

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

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

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

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
2019-20	6	7	7	11	3	7	21	16	14	12	21	15	140
2020-21	20	14	10	14	11	13	6	11	14	5	15	9	142
2021-22	6	4	10	7	8	9	7	15	13	8	16	9	112
2022-23	6	13	6	6	6	5	9	14	5	8	6	10	94
2023-24	4	8	2	9	9	8	2	3	9	5	8	0	67

Grand Total	**42**	**46**	**35**	**47**	**37**	**42**	**45**	**59**	**55**	**38**	**66**	**43**	**555**

National Patient Safety Alerts Financial Year / Month													
Type of Alert	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
2021-22	0	1	3	1	3	0	0	1	0	0	0	2	11
2022-23	1	1	1	0	2	0	1	2	0	2	1	0	11
2023-24	0	3	1	2	1	2	0	1	3	2	2	0	17
Grand Total	1	5	5	3	6	2	1	4	3	4	3	2	39

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

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

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

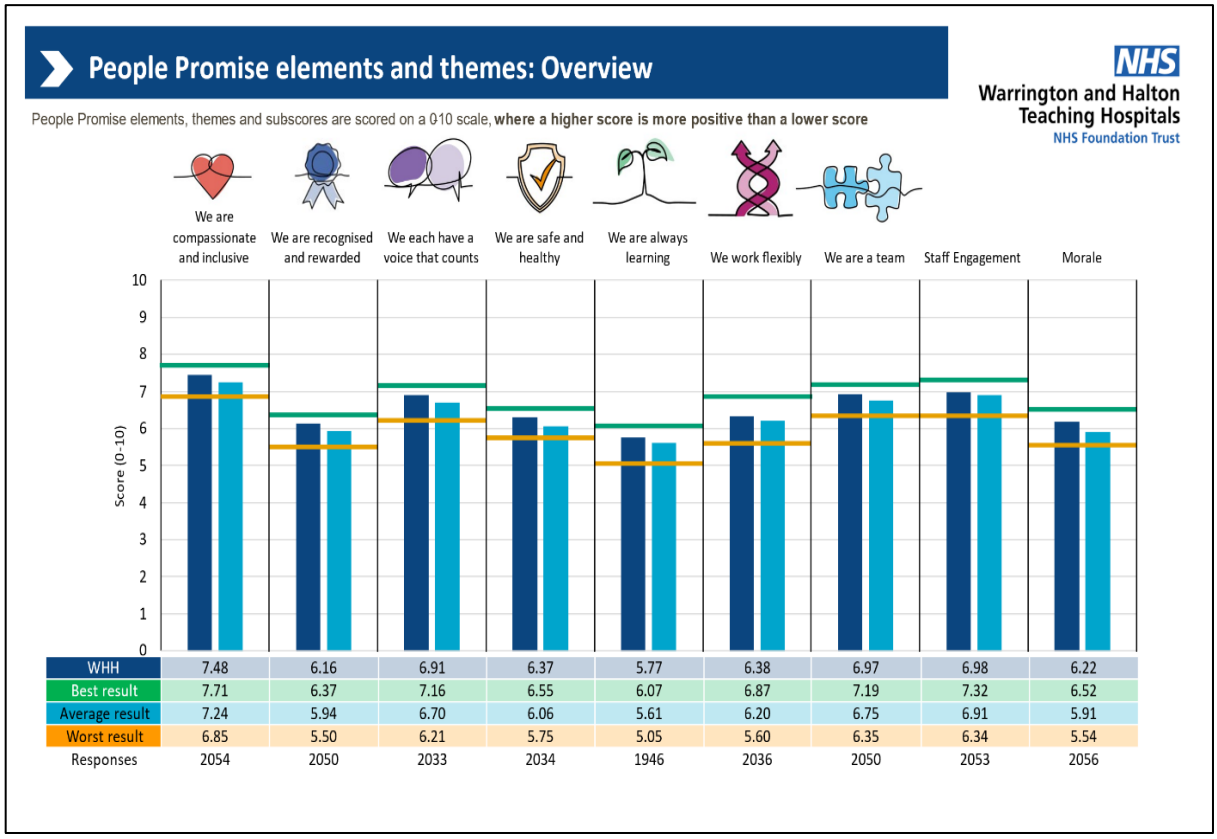
4. Where necessary for an alert such as a National Patient Safety Alert (NatPSA), as required distribution will also include an executive lead with oversight of the project related to the needs of the alert, to completion of all actions and closure to the Central Alerting System (CAS) website.

3.15 Staff Survey Results.

All NHS Trusts are required to survey their workforce annually using the National Staff Survey. The survey comprises around 100 questions. The NHS England benchmark reports are themed in line with the seven NHS People Promise areas that are reflected in the 2023 staff survey results.

People Promises and Themes in the 2023 Staff Survey	
People Promise (PP) / Theme (T)	**Sub-score / Theme**
We are compassionate and inclusive (PP)	• Compassionate culture • Compassionate leadership • Diversity and equality

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



The most updated results from the 2023 NHS Staff Opinion Survey results for the themes of "We are Compassionate and Inclusive" and "We are Safe and Healthy" are as follows:

We are compassionate and inclusive.

The Trust scored 7.48% for this theme overall which is higher than the 2022 score of 7.3% and higher than the comparator organisations of 7.24. For question 15 Does your organisation act fairly with regards to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age the Trust scored 62.48% compared to the Acute Trust average of 55.89%. The Trust are above the national Acute Trust average, however, recognises the importance of ensuring equity in relation to progression and promotion. The introduction of the Your Future Your way programme is one such example of this.

The organisation has a Workforce Equality, Diversity, and inclusion Strategy (2022-2025) which includes refreshed workplans and objectives based on staff survey intelligence annually. There are also specific action plans in place aligned to the Workforce Race Equality Standard and the Workforce Disability Equality Standard to continue to improve the experience of our workforce in relation to acting fairly in terms of career progression or promotion irrespective of protected characteristic. This is reported through our Strategic People Committee on a bi-annual basis to ensure monitoring of improvements and that actions meet targeted deadlines.

Aligned to the introduction of the NHS equality, diversity and inclusion improvement plan in June 2023, further work has been completed based on the results of the 2023 staff survey to ensure that disparities experienced by certain protected characteristics are addressed.

We are Safe and Healthy.

The Trust scored 6.37% for this theme which is higher than the comparator score of 6.06% and slightly below the best scoring organisation in this category who achieved 6.55%.

In relation to harassment, bullying or abuse question 14b asks "how many times have you personally experienced harassment, bullying or abuse at work from managers? The Trust scored 7.42% which is an improvement from the 2022 score of 10.9% and lower than the comparator Trust score of 10.49%. In 2023, the Trust saw an improvement across the protected characteristics for race, disability and sexual orientation, in terms of the disparity of those reporting harassment, bullying or abuse at work. There still remains further work to do in this area and this is monitored through the Workforce Equality, Diversity and Inclusion Sub-Committee, chaired by the Chief People Officer.

The organisational programme of kindness, civility and respect continues which has been integrated with the Patient Safety Incident Response Framework (PSIRF) program of work to effect organisational cultural change. In addition, this intelligence feeds into our organisational People Strategy to ensure all workstreams focus on improving the experience of our workforce.

For question 14 – "In the past 12 months how many times have you personally experienced bullying, harassment, or abuse at work from other colleagues? The Trust scored 15.93% which is lower than the 2022 score of 19.2% score and remains lower than the Acute Trust comparator average of 19.25%.

3.16 Ockenden Report.

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

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

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

The final position at the close of 2023/2024 is as follows:

- Ockenden Part 1a: 100% compliant.
- Ockenden 1b: 100% compliant
- Ockenden 2: 100% compliant. Ockenden 2 does not have any set national timelines, but the Trust has set internal timelines which was to achieve all actions by 31 March 2024.

During 2024-25, the monthly Women's and Children's CBU Governance Meetings and the monthly Quality Assurance Committee (QAC) will continue to monitor compliance.

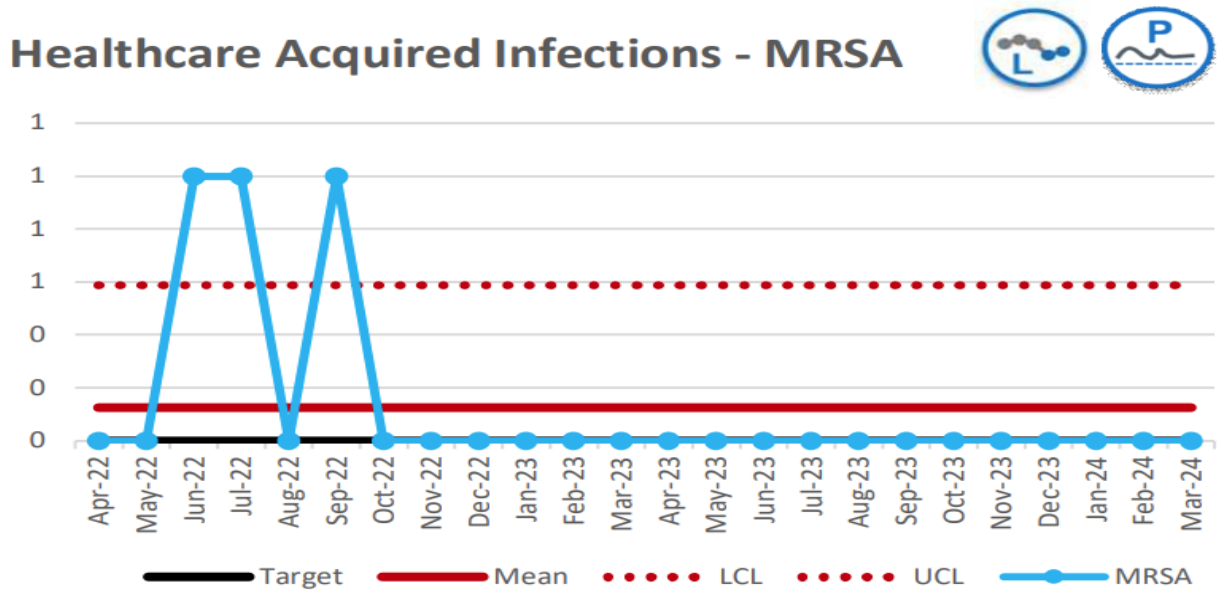
3.17 Healthcare Associated Infections.

An overall summary of Gram-Negative Bloodstream Infections (GNBSI) and Healthcare Associated Infections has been provided in the table below for 2023-24. The national and local data for the full financial reporting period has been included.

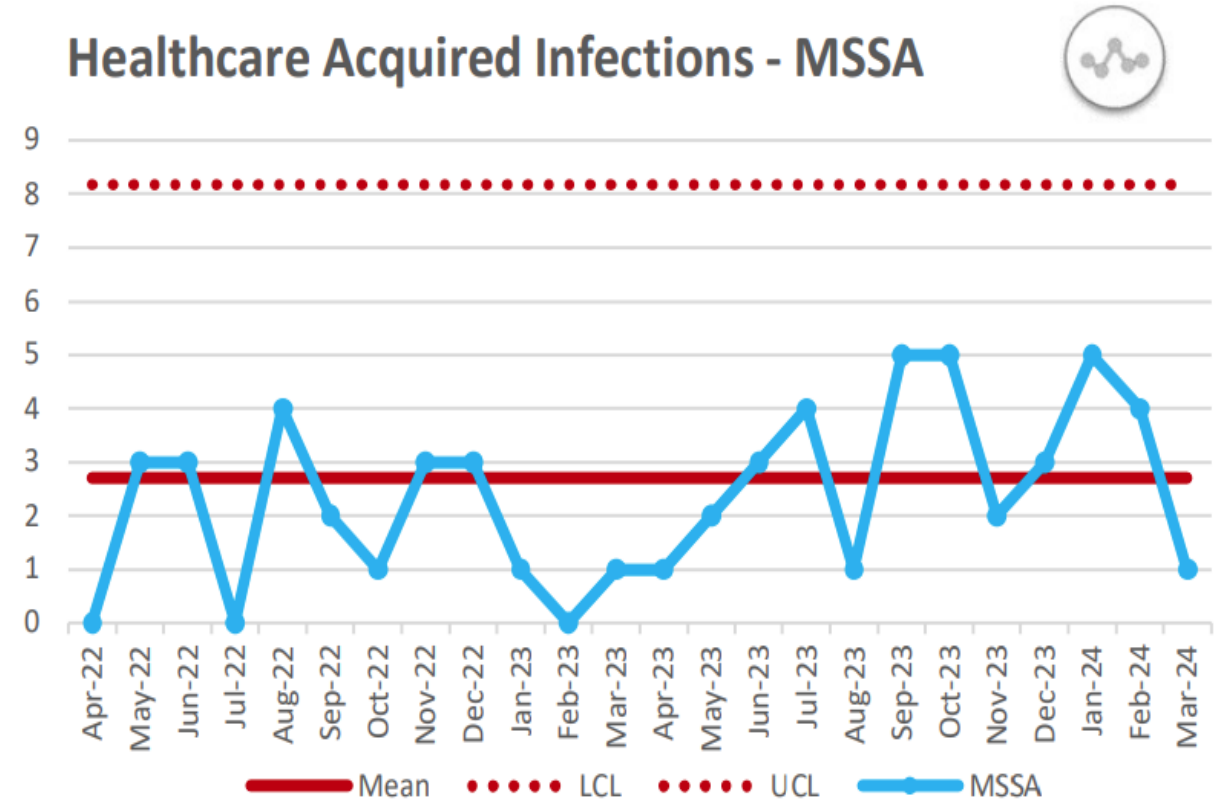
Number of Hospital Apportioned Cases Reported 2021-22	Number of Hospital Apportioned Cases Reported 2022-23	Number of Hospital Apportioned Cases Reported 2023-24	Mandatory Reportable Healthcare Associated Infections
1	3	0	Methicillin-Resistant Staphylococcus Aureus (MRSA) 1 case was considered unavoidable
29	21	36	Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA) *
46	55	55	Clostridioides Difficile (C. Difficile) cases. C. Difficile cases include community onset/healthcare associated and hospital onset/healthcare associated cases.
			Gram-negative bloodstream infections (GNBSI)
46	67	81	E. Coli Bacteraemia (Gram Negative)
26	22	28	Klebsiella Bacteraemia
3	4	11	Pseudomonas Aeruginosa Bacteraemia
*There are no targets set nationally for MSSA bacteraemia cases.			

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

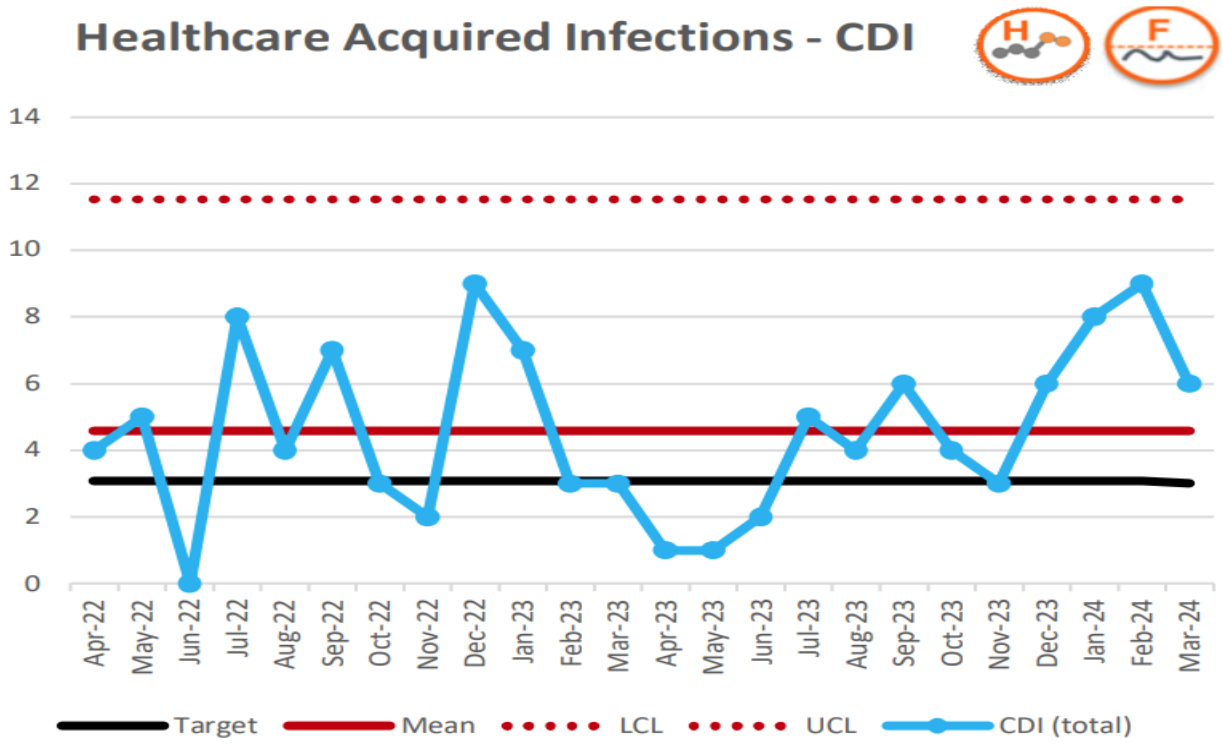
Graph 1 shows the results for MRSA bacteraemia cases in 2023-24.



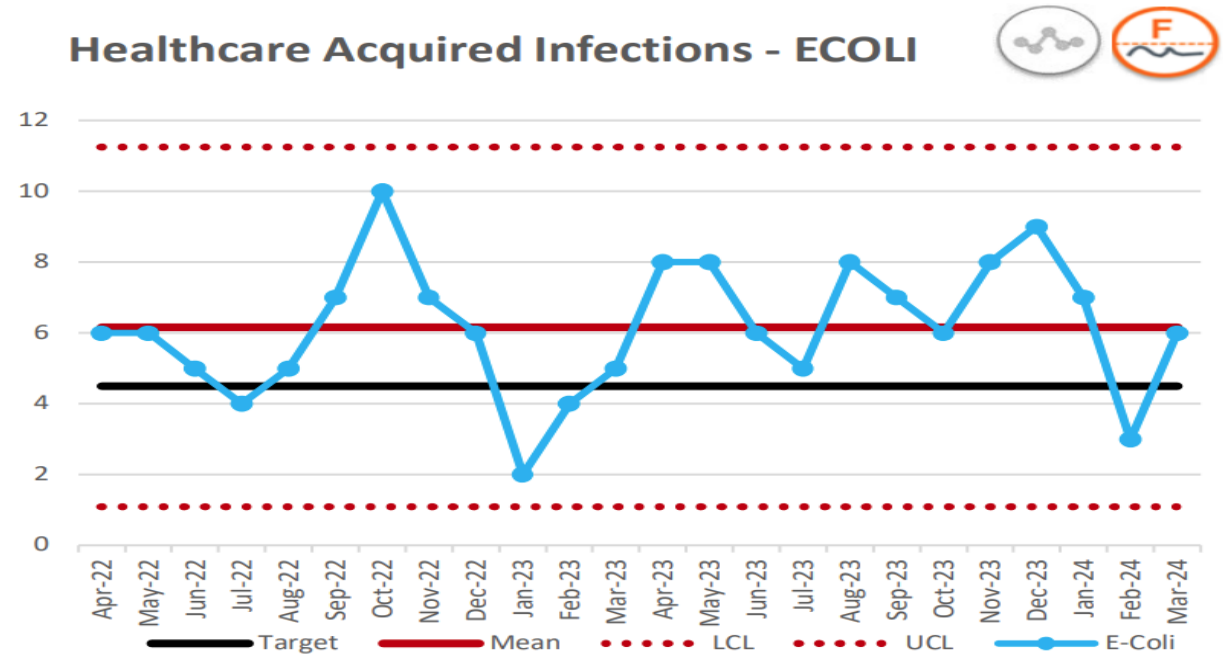
Graph 2 shows the results for MSSA bacteraemia cases in 2023-24.



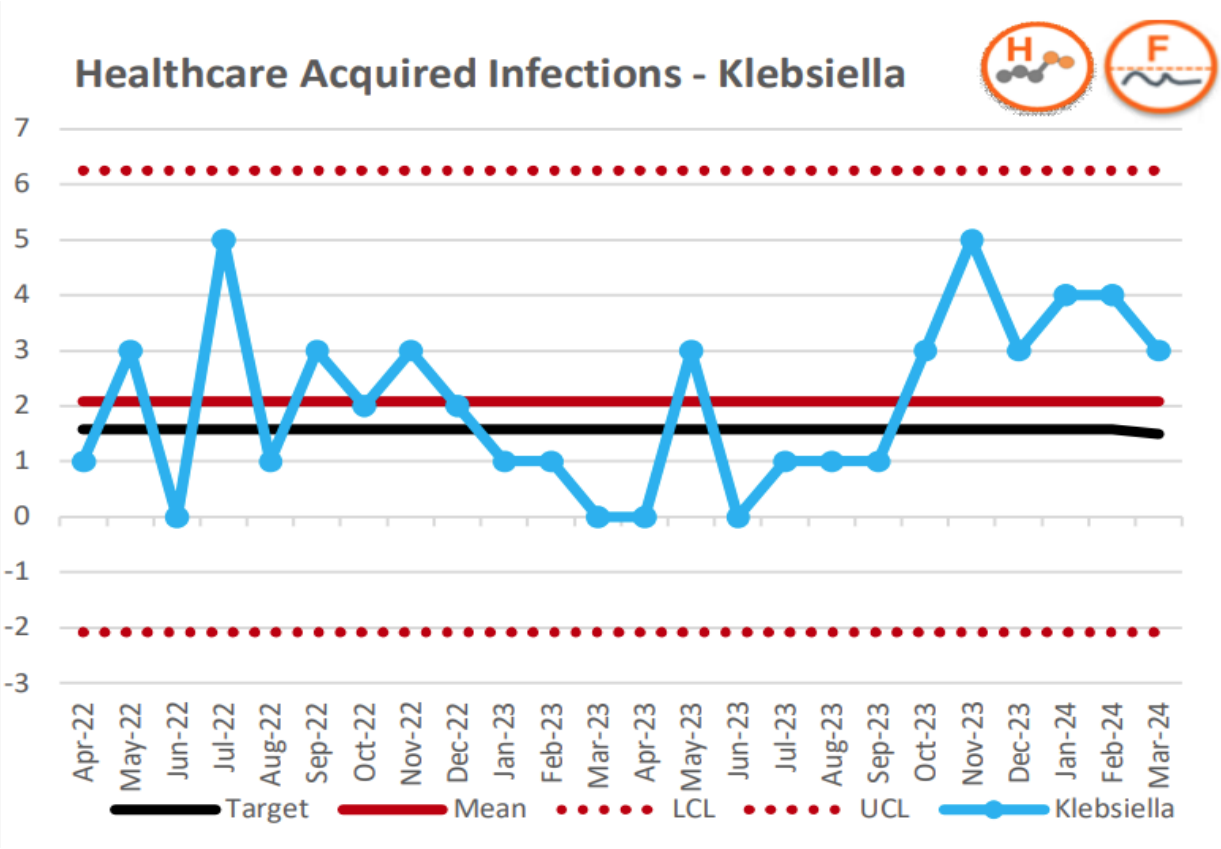
Graph 3 shows the results for Clostridium Difficile Infections (CDI) cases in 2023/24.



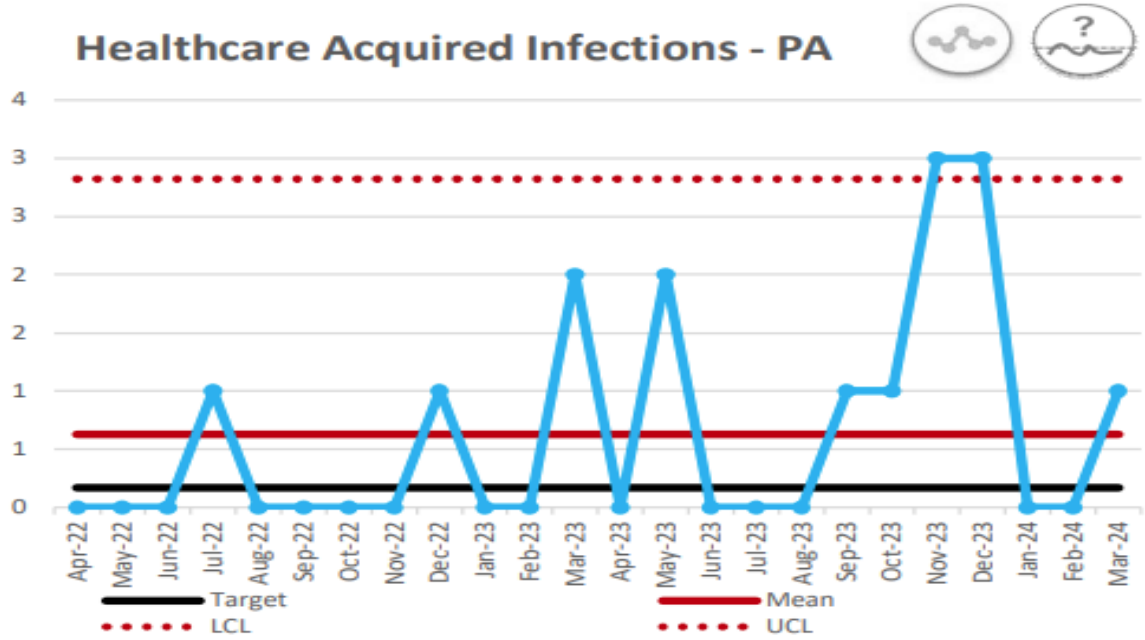
Graph 4 shows the results for E Coli Bacteraemia cases in 2023/24.



Graph 5 shows the results for Trust Apportioned Klebsiella spp. Bacteraemia Cases in 2023-24.



Graph 6 shows the results for Trust Apportioned Pseudomonas Aeruginosa Bacteraemia cases in 2023-24.



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

Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia.

With regards to Health Care Acquired Infections (HCAI) during 2023/24, the Trust threshold was 0 cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, which was met. The Trust has been a rolling MRSA bacteraemia free for 18 months.

Methicillin-sensitive Staphylococcus Aureus (MSSA) bacteraemia.

The Trust also carefully monitors Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia. The Trust reported 36 Trust apportioned cases of MSSA bacteraemia during the financial year. This is an increase of 15 cases compared to the previous financial year. Some of these cases arose from deep seated infections that could not be prevented. An action plan is in place that sets out the work required to prevent the risks of MRSA/MSSA bacteraemia cases.

These cases are under review to identify any areas for care improvement.

Clostridiodes (Clostridium) difficile.

In relation to Clostridium Difficile the Trust reported 55 cases against the annual threshold of 36 Trust apportioned cases. Case numbers are unchanged from the previous financial year. C. Difficile cases include community onset/healthcare associated and hospital onset/healthcare associated cases.

An overall summary of Gram-Negative Bloodstream Infections (GNBSI) has been provided below for 2023-24. Gram Negative Bloodstream Infections include:

- E. coli bacteraemia.
- Klebsiella spp. Bacteraemia.
- Pseudomonas Aeruginosa Bacteraemia.

In relation to Gram Negative Bloodstream Infections, the Trust had a target to achieve a 5% reduction in Gram Negative Bloodstream Infections (GNBSI).

Background to Gram Negative Bloodstream Infections.

- In 2019 there was an addendum to the UK's antimicrobial resistance plan which was to continue work to halve healthcare associated Gram-negative bloodstream infections, by adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

Gram Negative Bloodstream Infections (GNBSI) and Healthcare Associated Infections - Implementation and Performance:

Despite efforts made, the Trust did not achieve the 50% reduction in GNBSIs by March 2024. A breakdown of each of the GNBSI cases is detailed below.

E. coli bacteraemia.

The Trust reported 81 Trust apportioned cases of E. Coli bacteraemia during the financial year This is an increase of 14 Trust apportioned cases of E. Coli bacteraemia cases compared to the previous year.

Klebsiella spp. Bacteraemia.

The Trust reported 25 Trust Apportioned Klebsiella spp. bacteraemia Cases during the financial year This is an increase of 3 Trust apportioned cases of Klebsiella spp. bacteraemia cases compared to the previous year.

Pseudomonas Aeruginosa Bacteraemia.

The Trust reported 11 Trust Apportioned Pseudomonas aeruginosa bacteraemia cases during the financial year This is an increase of 7 Trust Apportioned Pseudomonas aeruginosa bacteraemia cases compared to the previous year.

Partnership working is in place across the health economy and the Trust is working with community partners to progress action plans. Work streams related to the reduction of healthcare acquired infections continue with oversight at the Patient Safety Sub Committee and the Quality Assurance Committee.

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.

3.18 Quality Academy Overview.

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

Objectives.

Our Key priorities for the Quality Academy are:

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

Engagement.

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

Quality Academy Showcase.

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

This year the event hosted a record number of attendees and outstanding examples of work to demonstrate how we deliver safe, effective, and compassionate care were showcased through oral and poster presentations. A series of breakout sessions offered more opportunities to share learning and network. The day was highlighted by expert presentations from Professor Michael West on compassionate leadership and Julia Wood on Joy in Work.

Figure 1: Pictures from the 2023 Quality Academy Showcase

3.19 Quality Academy: Continuous Quality Improvement (CQI).

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

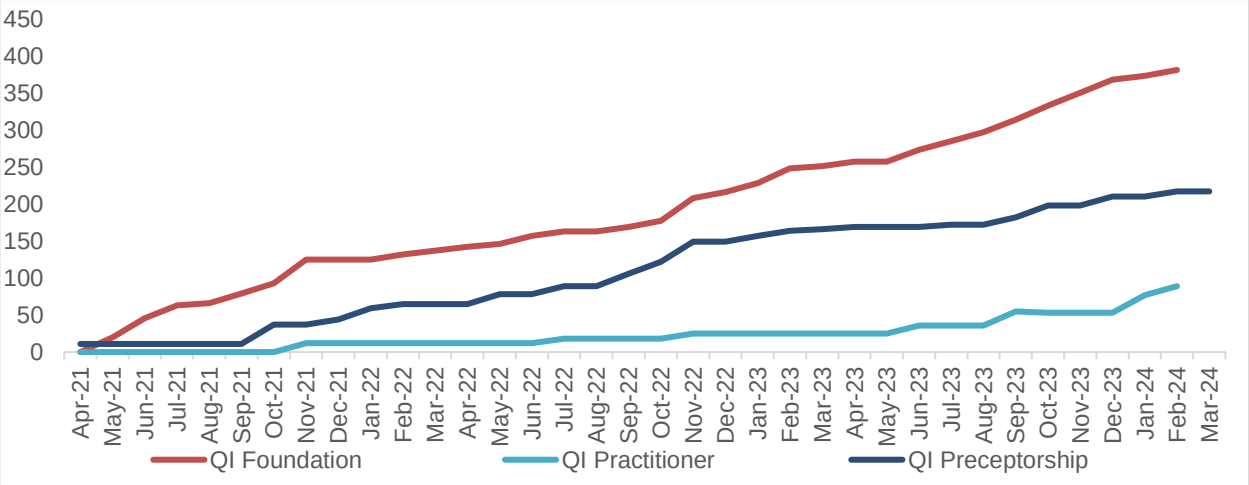
1. Developing improvement capability at all levels of the organisation.
2. Building and sustaining a culture of continuous improvement.
3. Supporting the application of QI methods to key patient safety improvement areas.
4. Further developing internal QI Systems and Processes.

Quality Improvement
Warrington and Halton Hospitals
NHS Foundation Trust

1. Developing improvement capability at all levels of the organisation

The CQI Team deliver a programme of internal training to support Trust staff to gain the knowledge and skills required to deliver QI projects in their own areas. This year a specific quality priority was set to increase QI capability and capacity by 10% (400 staff members) for the QI Foundation training and 2.5% (100 staff members) for the QI Practitioner Programme. QI training also forms part of the training programme for all multi-professional preceptees within the Trust. An improved position has been identified during financial year 2023/2024, although we have not met the ambition regarding the numbers of staff trained due to capacity and demand for training delivery. To date, 381 staff have received training in QI foundation level and 89 staff have received or have training programme in progress for QI Practitioner level training.

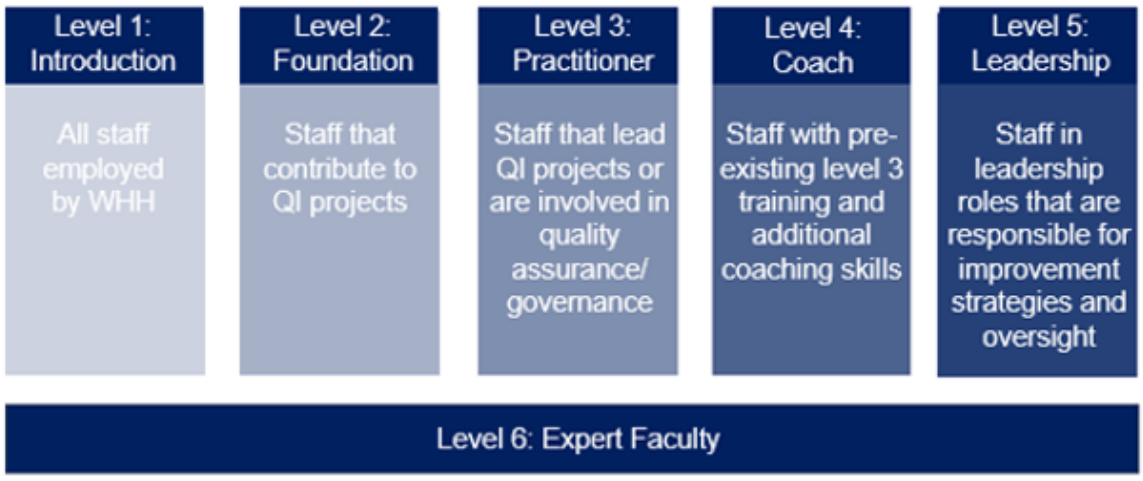
Figure 1: The number of staff trained over time in the QI Foundation, Practitioner and Preceptorship programme.



It is widely recognised that a systematic approach is required for success across an organisation and a forward plan for developing improvement capability and capacity has been updated this year. To fully commit to building capability and capacity across the organisation we need to be ambitious in our approach and ensure the knowledge and skills developed from QI specific training can be demonstrated in parallel across all levels of the organisation.

This year, in line with the newly launched NHS Impact (Improving Patient Care Together) recommendations, we have defined as an organisation to build a foundation of six levels of CQI capability which is targeted to the role that each staff member has to play in supporting our culture for improvement. The training ranges from level one (an introduction to QI) to level 6, which is represented by our Expert Faculty and an implementation plan for this is in progress.

Figure 2: The Warrington and Halton Six levels of QI Training



2. Building and sustaining a culture of continuous improvement

Care Quality Commission (CQC) QI maturity self-assessment and the organisational approach to improvement.

As part of a quality priority for this year, we have developed an evidence base for self-assessment against the CQC criteria required to demonstrate a mature organisational QI approach. A target was set to achieve 80% compliance with the metrics required and the work has been linked to the broader mock inspection programme and Moving to Outstanding (M20) work in collaboration with CQI and Compliance Teams. It is anticipated that we will achieve over 80% compliance based on our self-assessment this year, and developmental plan will be developed to be aligned with the CQC's new Single Assessment Framework within the next financial year.

Quality Improvement Practitioner Community (QIPC).

The CQI Team have developed a Quality Improvement Practitioner Community (QIPC) this year to support the vision of embedding sustainable CQI through a community of practice approach. The community is designed to build coaching skills and the capability of the practitioners to further support quality improvement work within their departments or across the Trust on a wider scale. Those trained and developed to practitioner level (level 3) with a passion for QI have come together to share experiences, learn from guest presenters, take part in development workshops such as Liberating Structures, QI Coaching and enjoy a multidisciplinary forum for shared problem solving.

QIPC has been co-produced with practitioners and the outline plan is based on feedback from the first two events to include:

- Quarterly larger scale 2-hour events:
  - QIP update presentations.
  - Coaching workshops
  - QI training/process peer reviews
- Bi-Monthly 'hot topic QI cafe'
  - 1hr drop in event with discussion/support on a themed topic.
  - Themed topics will be submitted for choice by the leaders prior to the date.
  - It will be open to all interested staff across the Trust.

Shared Learning Forum.

To further develop a culture of learning and improvement, a Shared Learning Forum was launched in February 2024 with an aim to provide an opportunity for WHH colleagues, partners, and people with lived experience of our services to share, learn and engage in interactive activities. The vision is to bring together improvement and innovation projects, from a wide range of quality and safety related initiatives, share patient and staff feedback, and celebrate and learn from excellent practice- both clinical and non-clinical services.

The outline plan is to hold quarterly event to build momentum with themed topics and patient engagement through our Experts by Experience.

3. Supporting the application of QI methods and tools to key patient safety improvement areas.

The central CQI team support a programme of Trustwide QI projects that are linked to deliver key priorities of patient safety improvement within various workstreams.

Falls Collaborative.

The 2021-2023 Trust wide falls collaborative focused on reducing inpatient falls within the Trust and concluded in March 2023 with change package implementation to be embedded across the wards. Since then, improvement work has continued and collectively the Trust achieved a 35.8% reduction in the number of inpatient falls since January 2023. This reduction has been sustained over time and work is ongoing with the Patient Safety Improvement Nurses and service leads/managers with reporting and monitoring of inpatient falls governed by the Operational Patient Safety Group.

Pressure Ulcer Collaborative.

The 2021- 2023 Trust wide Pressure Ulcer Collaborative focused on reducing hospital acquired pressure ulcers within the Trust with change package implementation to be embedded across the wards. The formal collaborative finished in March 2023 and work is ongoing to reduce the number of pressure ulcers as identified by the Trust 2023-2024 quality priority. A post collaborative review was undertaken, a Task and finish Group will be formed to develop new plans for the next financial year and drive further improvement.

Dr EaMing (Drinking, Eating and Mobilising post-surgery).

Led by the Planned Care Group, a project team has assembled to join a National QI collaborative to improve the number of patients that are “dreaming” post-surgery. This is linked with the Trust CQUINs 2023-2024, and work is ongoing to support development of a QI project with an aim to increase patient involvement in Dreaming as part of their elective operative care pathway.

Theatre and Surgical Safety Collaborative.

As a member organisation with Advancing Quality Alliance (AQuA), WHH Theatre Services Team was selected in a nine-month improvement collaborative led by AQuA, which completed on 6 December 2023. AQuA provided dedicated coaching and learning sessions for the Theatre Team for this project and aimed to establish consistent practice in line with the revised National Safety Standards for Invasive Procedures (NatSSIPs). This has resulted to establish the Trust’s Procedural Safety Standards Steering Group, which is composed of multidisciplinary team members and leaders, including representatives from Quality Academy.

An overview of additional Trust wide or large-scale Quality Improvement Projects

Emergency Department (ED) Triage and Ambulance Handover.

A Triage (front of house) Improvement group has been established and supported by the CQI Team, to reduce the average time from arrival to initial assessment in ED from 23 minutes to 15 minutes. This is part of a wider ED improvement workstream to improve our position in reducing the number of 12-hour breeches in ED for patients that are waiting for admission to a ward.

Work undertaken in 2023 has led to the implementation of a waiting room nurse role following a test of change. Further tests of change are planned in March and April 2024 to move the navigator role to a senior triage role, and to implement the Manchester Triage System (a clinical risk management tool).

The CQI team have also been working in partnership with the Northwest Ambulance Service (NWAS) and the Emergency Department (ED) team to improve ambulance handover times. In 2023 observations and process mapping was carried out. Data analysis identified that days with high number of attendances impacted on increased ambulance handover times the following day.

This work is closely interrelated with the Triage Improvement Group and work is underway to implement rapid assessment and treatment (RAT) via early senior assessment of ambulance handovers, develop and redesign the ED footprint and allow direct access of ambulances to the SDEC area.

The CQI team has supported the group by providing advice, assistance with data measurement, process mapping and supporting the application of other relevant QI tools and methodology within the project group. Work will continue in this priority area in 2024-2025.

Sepsis Improvement.

The CQI Team supported the Trust's Sepsis Improvement Group as part of a wider quality priority to improve the recognition and response to deteriorating patients. The group identified different needs and challenges in different clinical areas which led to the establishment of five task and finish sub-groups:

- Inpatients
- ED
- Maternity
- Paediatric inpatients
- Paediatric ED

Following the release of a new national sepsis screening tool, the Sepsis Improvement Group will decide on how the tool is to be implemented, which will determine the work plan progression in 2024/ 2025. Sepsis data continues to be regularly reviewed using SPC (statistical process control) charts to monitor progress.

A specific example of improvement work within the maternity group centres around the Sepsis Six pathway documentation. Following on from a clinical audit produced by the audit and assurance midwife, it was discovered that there was no documentation in Badgernet (the maternity electronic record system) that the sepsis six pathway had been followed. A manual audit of clinical practice however showed 100% compliance with the pathway. To assist the group with using QI tools to address this, Fishbone analysis and a driver diagram was completed and change ideas identified. All change ideas have been implemented and an audit to measure success is scheduled one an appropriate number of patients data is available.

Medicines Management.

The QI Team have provided additional coaching and support to the team taking part in this AQuA collaborative focussing on improving availability and timely administration of critical medicines.

As a result of this work the pharmacy services manager has been identified as a local improvement lead and will feed into a pharmacy improvement group which the QI team will continue to support.

Urinary Catheter Removal.

The urinary catheter removal improvement project was set up to lead on from the larger Gram-Negative Blood Stream Infection (GNBSI) collaborative to provide more focus in this area. Following a period of CQI lead support the project group is now independently managing this project.

Post Partum Haemorrhage (PPH).

A Quality Improvement Project group was formed with the aim to reduce the occurrence of PPH at WHH by October 2024. Through the application of specific methodology, inconsistencies in the recognition, recording and learnings from PPH occurrences were identified. The project is in its early stages and work continues with the guided application of QI methodologies.

Frailty Service Improvement.

As part of the ECIST (Emergency Care Improvement Support Team) and GIRFT (Getting It Right First Time) action plan, the hospital and system leaders at WHH are advised to undertake a frailty review to understand the demand to plan the capacity required to ensure people presenting with a frailty syndrome are managed by the right team, first time. This should include the workforce requirements, alternatives to ED and provision of services.

The pathways surrounding the Frailty Service are multifaceted and complex. Therefore, a QI approach has been identified as necessary to analyse capacity, value stream, waste analysis and identify a sustainable approach to maximise the efficiency of the service, whilst supporting patient flow. Early thematic analysis suggested ambiguity over qualifying criteria for FAU admittance, ineffective coordination resulting in waste of resource and long-established redundant practices still in use. The improvement workstream continues to be facilitated by the central CQI team with a multidisciplinary project team including Consultant Geriatrician and Consultant Nurse as project leads.

Local Quality Improvement Projects (QIPs).

The management of quality improvement projects and systems to disseminate evidence of learning and improvement has undergone a period of evaluation and redevelopment this financial year. Teams across the Trust are encouraged to develop their own QIPs using robust QI methodology to drive improvement in their local areas.

Local QI initiatives and projects that have been completed have highlighted the following learning over the course of the financial year:

- Falls reduction- staff engagement with patients increased (through use of an activity trolley), and the importance of wearing do not disturb aprons so staff supervising patients at increased risk of falls can be identified.
- Positive impact of increased usage of evidence-based resources (Clinical Skills.net).
- To ensure fractured hip patients are treated within national standards.
- Mental Capacity Act- the use of E-learning and importance of improving bespoke face to face training, highlighted lack of appropriate documentation.
- Pressure Ulcers- use of a traffic light system visual alert to highlight patients at risk of developing pressure ulcers and identify appropriate intervention.
- Reducing the time to administer medications on a medical ward did not lead to an increase in medication related incidents.
- Stopping inappropriate requests to GPs from the frailty assessment unit and introduction of internal referral process to metabolic bone clinic to reduce GP requests.
- Psychological safety within the Acute Therapy Team- adopting the key behaviors needed to improve psychological safety can markedly improve the wellbeing, morale, and performance of a team.

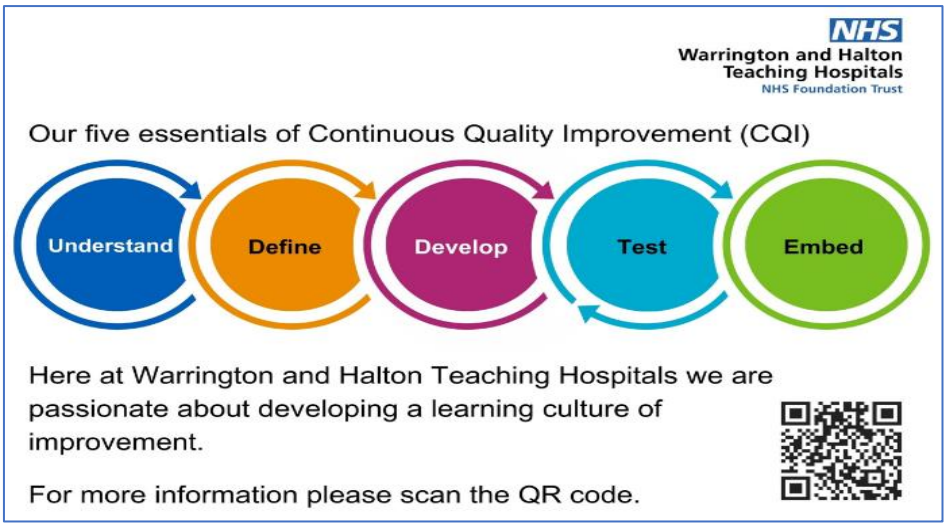
5. Further developing internal CQI Systems and Processes.

To improve the management of quality improvement and QIPs across the Trust, the CQI team have implemented a review and update of our management system.

WHH CQI Framework: The Five Essentials of CQI.

The Trust have launched in late 2023 the new harmonised CQI framework called ‘WHH’s Five Essentials of CQI’ to form the foundation of all quality improvement across the Trust after a series of staff and senior leaders’ consultation and co-designed with input from Experts by Experience. The infographic and design serve as a visual prompt and branding to support the development of a QI culture within the trust. This standardised approach is complemented by development of a suite of supporting tools and QIP certification criteria, that are available to all staff.

Figure 3: The five essentials of CQI

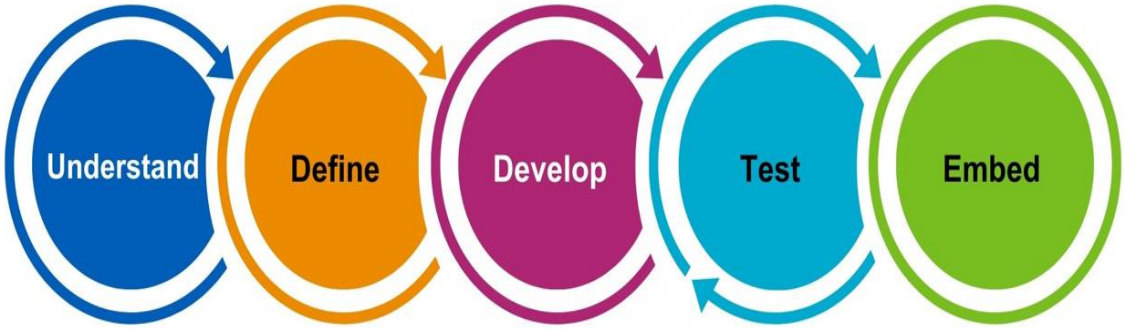


The review of CQI management system is ongoing and work has progressed to standardise and streamline our internal processes. As we continue to refine and improve how we operationalise QI at WHH, we anticipate that this will have a positive impact on the other three CQI team drivers. A summary of the key developments this year include:

- Development of a standard project progress and assessment criteria based on the IHI (Institute for Healthcare Improvement) standard assessment scale to assess the quality of completed projects *(see figure 4 for further details).*
- Launch of a quick reference guide for QIPs.
- Development of a QIP Standard Operating Procedure (SOP), which outlines a more robust system of identifying projects that have not progressed or have been completed and the escalation routes through the governance process.
- Established QI agenda items on Care Group/CBU Governance Meetings, with an allocated CQI lead for each care group.
- Refreshed database of QIPs and themes, which are sent to governance managers for their respective CBU oversight monthly meeting, to cross reference against improvement actions in line with the Patient Safety Incident Response Framework (PSIRF) implementation.
- Operational Patient Safety Group reporting redesigned to include SPC charts where appropriate and improve the system to identify and report on related local QI work.

Figure 4: QIP certification criteria and criteria required to receive a certificate of excellence.

On completion of a Quality Improvement Project (QIP), the following must be evidenced to be awarded with a **Quality Improvement Project Certificate.** For further information, refer to the Quality Improvement Project Quick Reference Guide.



Criteria 1 – Understand

Evidence of investigating the problem and involving other people.

Criteria 2 - Define

Evidence of a clear aim and data collection to demonstrate the impact of change.

Criteria 3 – Develop

Evidence of generating several change ideas that may help to achieve your aim.

Criteria 4 – Test

Evidence of two or more completed PDSA (Plan, do , study, act) cycles

Criteria 5 – Embed

Evidence of a plan that ensures successful changes become standard practice and will be sustained beyond the life of the project.

In addition to the above, a "Certificate of Excellence in Continuous Quality Improvement" will be awarded for project leads/teams that demonstrate the following level of detail in their QIP:

Criteria 1 – Understand

- A clearly defined problem
- Stakeholder map and evidence of involving others to understand the problem.
- Involvement of patients / service users (unless not applicable).
- Evidence of one or more of the following tools or approaches:
  - Process Mapping / value stream mapping.
  - 5 Whys
  - Fishbone diagram
  - Pareto analysis
  - Waste analysis
  - Literature review / evidence summary

Criteria 2 – Define

- An aim statement which includes what you want to improve, by how much, by when and for whom. It should not include the solution or changes being implemented.
- Clear data collection methods, with data presented over time (e.g. run chart or SPC chart)
- Two or more types of measures that are clearly defined:
    - Outcome measure(s)
    - Process measure(s)
    - Balancing measure(s)

Criteria 3 – Develop

- For change ideas to be informed by problem analysis.

Criteria 4 – Test

- Evidence that the results of PDSA cycles were used to determine next steps / next PDSA cycles.
- A record of findings and learnings.

Criteria 5 – Embed

- A clear plan of next steps and sustainability analysis.
- Evidence of reflection and learning.

It is anticipated that as the Warrington and Halton CQI Management System continues to be refined and more widely communicated, QI training levels continue to increase and our culture for QI is built, more QIPs with reach the criteria required to be awarded with a certificate and a certificate of excellence. All certifications will be shared and celebrated as part of a series of improvement celebration events.

Annexes

Annex 1: Quality Account Statements

Statements from Integrated Care Boards (ICBs), Local Healthwatch Organisations and Local Overview and Scrutiny Committees and other stakeholders 2023-24 are presented within this document unedited by the Trust and are produced verbatim.

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

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

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

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

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

Statement from the NHS Cheshire and Merseyside Integrated Care Board (ICB) on the Quality Account – 11 June 2024

Cheshire And Merseyside Place representatives along with NHSE/I Specialist Commissioning welcomed the opportunity to jointly comment on the Warrington and Halton Teaching Hospitals NHS Foundation Trust Draft Quality Account for 2023-24.

We understand the continuing pressures and challenges for the organisation and the local health economy over the past year and recognise that these challenges are ongoing.

Commissioners have worked closely with the Trust throughout 2023/24 to gain assurance that the services you deliver were safe, effective, and personalised to patients. Halton & Warrington Places share the fundamental aims of the Trust and support their strategy to deliver high quality, harm free care.

Commissioners noted the priorities and individual measures from 2023/24 and supported the key priorities for the improvement of quality during this timeframe, which were:

Priorities for Improvement 2023/24

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

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

3. By focusing on patient experience, the organisation wants to place the quality of patient experience at the heart of all they do, where "seeing the person in the patient" is the norm.

We note the priorities, key achievements and progress made in 2023/24:

- Individual Places welcomed the presentation as well as an open, honest, and detailed report - demonstrating continuous quality improvement.
- Priorities for last year presented well and linked to key outcomes with detail of programmes of work provided.
- Places noted the achievement of Quality Priorities for 2023/24, particularly the focus on:
    - The Trust being a pilot site for the implementation of Martha's rule requirements.
    - Providing staff with Mental Health training – both ED specific and across inpatient setting.
    - Good work taking place in terms of improving patient experience for patients with mental health needs.
    - The implementation of PSIRF - a positive approach seen by staff. Challenges of culture change managing the audiology incident and the support of staff involved.
    - Embedding PSIRF and improving patient experience through partnership working including support and collaboration with ICB Place in sharing experience and learning with neighbouring Trusts and organisations.
    - Ensuring the equity of access and communication for patients with Learning Disabilities.
    - Positive results in the staff survey with improvement of indicators and culture scores from the previous year.
    - Evidence of award attainment and accreditations highlighted with good ambulance handover times continued.
    - Patient experiences and working with partners across the system.

The presented account indicates the Trust's commitment and clear rationale to improving the quality of the services it provides and supports the key priorities for improvement of quality during 2023/24.

Cheshire & Merseyside Places support the quality aims for 2024/25, particularly:

- Focused work on PSIRF and fragile services to inform quality improvement - moving to a more human factors approach.

- Improving the response to deteriorating patients and hospital acquired pressure ulcers – carrying forward focused aims given further improvement required. Learning and implementation to be in line with leadership.
- MUST improvement.
- Focus on supporting staff development in practice.
- Learning from the national audiology incident.

NHS Halton & Warrington Places recognise the continuing challenges for providers in the coming year and we look forward to working with Warrington and Halton Teaching Hospitals NHS Foundation Trust during 2024/25 as you continue to deliver improvement in service quality, safety and patient experience. In addition, we recognise the commitment of continuing to strengthen 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 and Warrington Places would like to take this opportunity to say thank you to Warrington and Halton Teaching Hospitals NHS Foundation Trust. To your staff for their care, courage, and commitment to the ensuring the people of Warrington, Halton and Cheshire receive high quality, safe and effective care and also for your on-going commitment locally to system partnership working.

Yours sincerely,

D. M- Roberts

Denise Roberts

Associate Director of Quality and Safety Improvement

Signed on behalf of the Associate Director of Quality and Safety Improvement for the following Places Liverpool, South Sefton, Southport & Formby and Knowsley Halton and Warrington.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Statement from the Trust's Council of Governors on the Quality Account – 9 May 2024

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2023/2024.

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.

One of the Governors prime roles is to focus on quality. As part of the Council's governance structure, it meets regularly with the Chair of the Trust and NEDs. At the meetings with the Chair and NEDs 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 CoG. The Governors have an observer at the Trusts Quality committee who reports to the CoG on the effectiveness of the NED in the role of Chair of the Trusts Quality committee.

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 24/25, the Governors agree with the priorities established and have had presentations during the formulation of the Priorities.

The Patient Safety Priorities relating to:

a) Ensure that all patients within ED receive timely assessment and treatment, resulting in improved patient experience and improved clinical outcomes.
b) Reduce elective long waits by having no patient waiting < 7 weeks for diagnosis test and improve performance.
c) Reduce the number of Category 2 pressure ulcers by 20% with zero tolerance of Category 3 and Category 4 pressure ulcers.

Clinical Effectiveness Priorities regarding:

a) Improve the safety culture in theatres with focus on consistency, psychological safety and learning evidenced through 95% compliance with Safe Surgery Standards aiming for no procedural Never Events in theatres.
b) Continue the GIRFT programme delivery and Trust GIRFT objectives in each of the Care Groups to deliver more timely and effective patient care
c) Continue to embed Patient Safety Incident response framework by developing organisational culture programme and leaning across the Trust.

The Patient Experience Priorities relating to:

a) Ensure that there are robust frameworks in place to care for patients with mental health challenges, evidenced through the implementation of a training package for nursing and medical staff, and 95% compliance with Mental Health Act assessment and detention documentation.
b) Improve discharge processes to support clinical demand and safe patient care, evidenced through a maximum of 15%bed occupancy in the number of No Right to Reside averaged over 12 months.
c) Ensure 95% compliance in the completion of assessments relating to nutrition and hydration with assurance of appropriate action undertaken to improve clinical outcomes.

The Governors are happy that the 2023/24 Quality Accounts Report provides data that is 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.

Governors find the format and section headings helpful. The Quality Accounts 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, members of the public and others who are interested in our hospitals and their performance to read the Quality Accounts Report.

Joint statement from Healthwatch Halton and Healthwatch Warrington on the Quality Account - 12 June 2024

Healthwatch Halton and Healthwatch Warrington welcome the opportunity to provide a commentary on this year's draft Quality Account report from Warrington & Halton Teaching Hospital NHS FT.

This year's report provides an in-depth and thorough overview on the progress made against last year's quality priorities and targets for this year's priorities. We do feel the reporting of progress against the Quality Priority objectives may have been easier to follow with the addition of a simple, 'Achieved' or 'Not achieved' against each objective.

We liked the clear presentation of the quality measures achieved by the Trust, (on page 40-42 of the draft report).

From feedback received from the public during the year, including at outreach sessions in both Warrington & Halton Hospitals, we believe this report gives a true reflection of people's actual experiences of the service.

The Trust continue to be responsive and willing to learn and improve from any issues Healthwatch has brought to its attention. It has shown a clear willingness to learn from people's experiences of treatment and care at the Trust, highlighted by the response to Healthwatch Warrington's report on the experience of Deaf patients which received a swift response and saw a full action plan for improvement.

We support the choice of Quality Priorities for 2024-25 and believe these are challenging enough to drive improvement. We will follow the progress on these with interest. As we have recently completed a joint report on the experiences of patients discharged from Warrington and Halton Hospitals, we have a particular interest in the work that will take place to improve the discharge process for patients.

On behalf of Healthwatch Halton and Healthwatch Warrington, we would like to pass on our thanks and appreciation to everyone at the Trust for their dedication and hard work on behalf of our communities during the past year.

Kind regards

Dave Wilson

Dave Wilson Chief Officer - Healthwatch Halton

Lydia Hughes Chief Officer – Healthwatch Warrington

Statement from Warrington Overview and Scrutiny Committee on the Quality Account – 11 June 2024

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

Statement from Warrington Health and Wellbeing Committee on the Quality Accounts – 11 June 2024

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

Statement from the Halton Health Policy Performance Board on the Quality Accounts – 11 June 2024

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

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

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

NHS Improvement has issued guidance to NHS foundation Trust Board of Directors on the form and content of Annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust 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 2023/24 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 1 April 2023 to 31 March 2024
    - Papers relating to Quality reported to the Board over the period 1 April 2023 to 31 March 2024.
    - Feedback from Cheshire and Merseyside Integrated Care Board dated 11/06/2024
    - Feedback from Council of Governors dated 09/05/2024
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated 12/06/2024 and Healthwatch Warrington dated 12/06/2024
    - Feedback from Overview and Scrutiny Committee dated 11/06/2024
    - Feedback from Halton Borough Council dated 11/06/2024
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11/06/2024
    - The 2022 national NHS adult inpatient survey published 12/09/2023. The 2023 survey is under embargo until August 2024
    - The 2023 national NHS staff survey published 07/03/2024
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2024
    - Care Quality Commission inspection report dated 24/07/2019. Care Quality Commission inspection report for Maternity Services dated 17/01/2024
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- the Quality Report has been prepared in accordance with the Quality Accounts regulations and guidance as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Steve McGuirk CBE DL QFSM,
Chairman

Date: 25 June 2024

Simon Constable FRCP,
Chief Executive

Date: 25 June 2024

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

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

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

Annex 4: Glossary of Abbreviation and Definitions

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

Abbreviations	Definitions
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.

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

Annex 5: How to provide feedback

We would like to hear your views on our Quality Account

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

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

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

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

Annex 6: Other formats and Quality Accounts Availability

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

Additional copies of the Quality Account can also be downloaded from the Trust website:
http://www.Quality accounts : Warrington and Halton Hospitals NHS Trust (Warrington and Halton Teaching Hospitals, NHS Foundation Trust .nhs.uk)

Our website

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

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

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