Quality Account

2021/22

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Quality Account 2021/22

Quality is our number one priority.

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

Part 1

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust is dedicated to the provision of high-quality care and clinical excellence. Recognising that our patients and staff deserve nothing less than OUTSTANDING, we have embarked on an organisation- wide journey referred to as 'Moving to Outstanding'.

I am pleased to present our Quality Account for 2021/22. The Quality Account is an annual report which reviews our performance and progress against the quality of services that we provide and outlines our key quality priorities for the year ahead. It is an opportunity to celebrate our continued achievements and improvements that have impacted upon the care of our patients and their families.

Looking ahead to 2022/23, we will continue to drive the Trust's Quality Strategy priorities. These are as follows:

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

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

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

The priorities have been chosen based upon national and local drivers and our internal governance intelligence, identifying areas for improvement. Emphasis remains upon working across organisational boundaries in partnership with others and across the Integrated Care System (ICS), to ensure that we provide efficient and safe patient pathways to optimise health outcomes and enhance patient experience. We aim to become an integrated provider of clinically and financially sustainable, acute and community services providing outstanding care.

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

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

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

Simon Constable

Chief Executive

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

The Quality Strategy 2021- 2024 demonstrates our commitment to improving the quality of care for our patients and describes how we planned to make this a reality. We believe that supporting our staff and equipping them with the right, skills, training, is fundamental in achieving our vision to deliver the highest quality of patient care, every day.

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

In 2019 the Trust was assessed as 'Good' in the Care Quality Commission (CQC) ratings, and we are working towards our 'Moving to Outstanding' rating for our patients and their families. This will be achieved by ensuring that all staff who work in our hospitals continue to strive for excellence in all that they do evidencing the provision of safe, effective and responsive care.

In 2021/22 the Trust has expanded provision within the Quality Academy recognising the fundamental role of quality improvement and research in improving patient outcomes and quality of care. This has included the introduction of the Halton Clinical Research Unit (HCRU) and a newly appointed Head of Research.

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

Kimberley Salmon-Jamieson
Chief Nurse and Deputy CEO

Paul Fitzsimmons
Executive Medical Director

Part 2

2. Priorities for Improvement and Statements of Assurance from Board

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

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

- **Quality - Patient Experience** – This section will be updated.
- **People - Employee Wellbeing & Engagement** - This section will be updated.
- **Sustainability - Work with other acute care providers** This section will be updated.

2.1 Organisational Structure

The Trust's organisational structure allows us to be more responsive to challenges through improved clinical engagement, strong and resilient leadership at all levels, with an emphasis on responsibility and accountability, to achieve the best for our patients and continuous improvement, transformation and innovation. The structure was developed collaboratively and facilitates clinical specialities within a Clinical Business Unit (CBU) model.

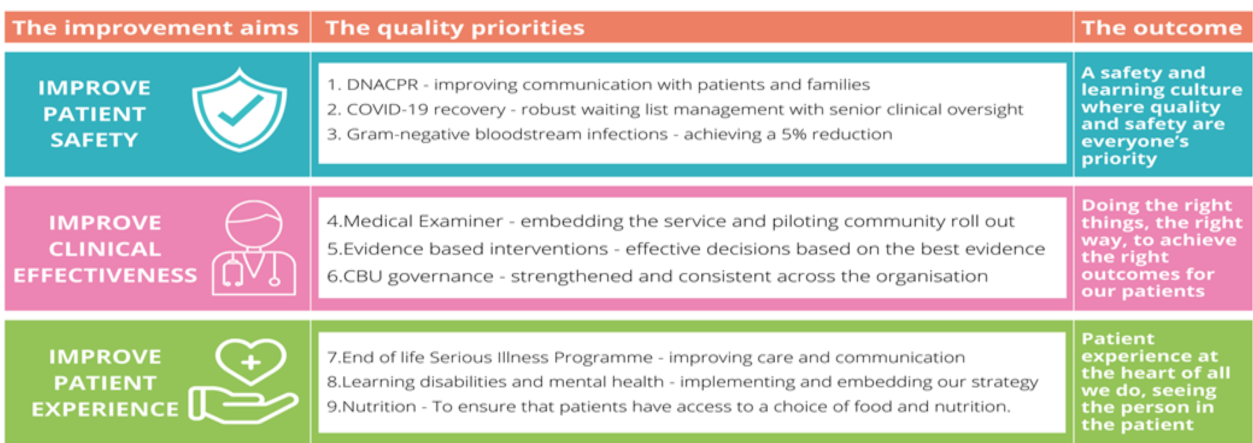
There are six Clinical Business Units within the Trust, who report into the Executive Directors. The Clinical Business Units are supported by 'Clinical Support Services' as well as 'Corporate Support Services'.

The Trust's organisational structure embraces the concept of true leadership synergy between the 'triumvirates' which brings together lead doctors, nurses/allied health professionals and managers working seamlessly with the wider corporate teams who are responsible for the clinical, operational and financial functioning of their CBU.

The CBUs have been created through innovation and collaboration with partners with the aim of improving access and quality of care, whilst being cost efficient through effective ways of working.

2.2 Priorities for improvement - Improvement Priorities for 2021/22 update

The following improvement priorities and quality indicators were identified following a review of the domains of quality.



OUR 2021–22 QUALITY PRIORITIES

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

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

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

The Quality Strategy uses the following measures of success:

- ✓ 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 following infographics details some of our key achievements from the Quality Priorities for 2021-22.

Key Quality

Achievements To Date

Complaints – Response Times Achieved

The Trust has successfully achieved 100% response rate within the allocated timeframe In December 2021, the Complaints Department had the lowest number of complaints open, 33 in total.

Consistent Incident Reporting

Incident reporting has significantly increased which demonstrates a positive reporting culture within the Trust. The data shows that there are high numbers of low/no harm incidents and low numbers of moderate/high/major harm incidents. This evidences a safe and transparent culture.

Achieved Statutory Duty of Candour Requirements

The Trust has achieved 100% compliance with notifying a patient of a verbal and written Duty of Candour within 10 working days after becoming aware that a notifiable safety incident has occurred.

Our 3 strategic objectives under the three priority quality domains are:

- **Priority 1 - Patient Safety:** The Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority.
- **Priority 2 - 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.
- **Priority 3 - 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.

The following section includes a report on progress with our improvement priorities for 2021/22 which were:

Patient Safety

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

Clinical Effectiveness

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

Patient Experience

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

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

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

Gram Negative Bloodstream Infections – Background:

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

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

Patient Safety and Clinical Effectiveness Sub-committee monthly.

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

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

An overall summary of GNBSI and Healthcare Associated Infections will be provided at the end of April 2022 when the national data is available.

Number of Cases Reported	Gram Negative Bloodstream Infections
1	Methicillin-Resistant Staphylococcus aureus (MRSA)
29	Methicillin-Sensitive Staphylococcus aureus bacteraemia (MSSA) *
46	Clostridioides difficile (C. difficile) (unavoidable, avoidable and cases awaiting review by the Clinical Commissioning Group (CCG) review panel to determine cause). C. difficile cases include community onset/healthcare associated and hospital onset/healthcare associated cases
63	E. Coli Bacteraemia
26	Klebsiella Bacteraemia*
3	P. Aeruginosa Bacteraemia*
*There are no targets set nationally for MSSA; Klebsiella, P. aeruginosa bacteraemia cases There is no nationally set target for MSSA.	

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

Graph 1 shows the results for MSSA bacteraemia and MRSA bacteraemia cases in 2021/22.

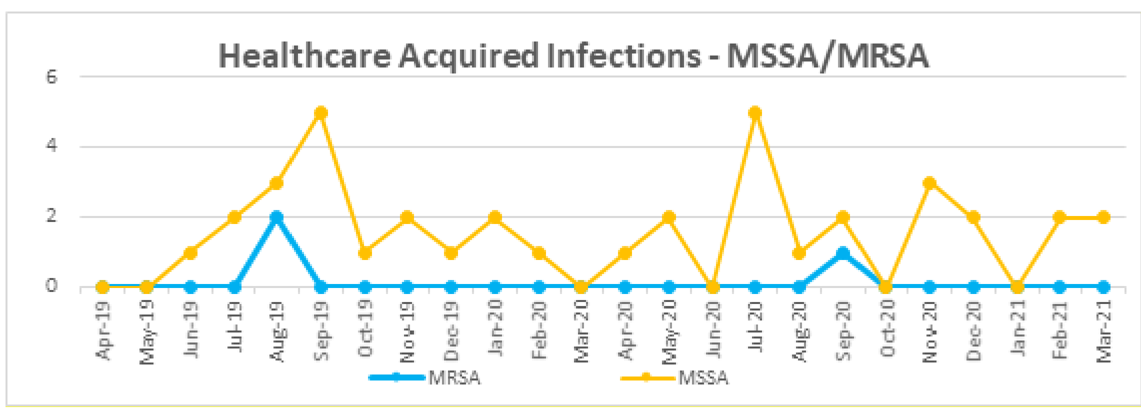
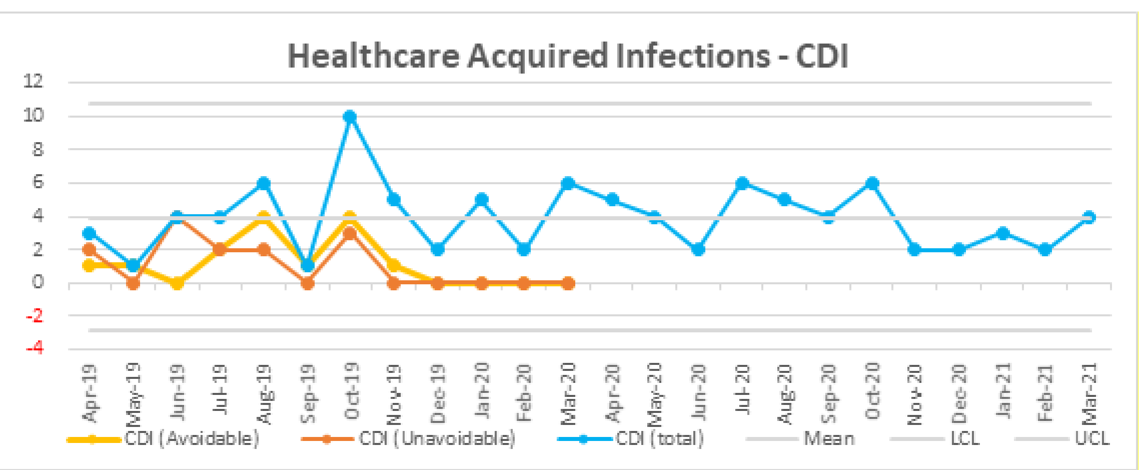
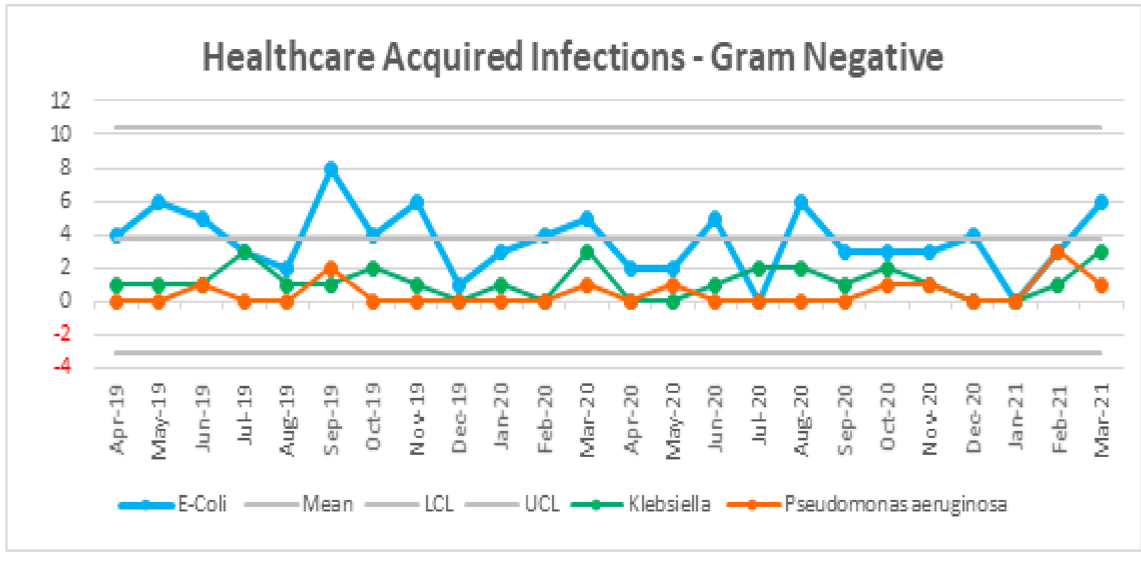


Table 2 shows the results for C. difficile cases in 2021/22. The data will be updated at the end of when the national data is available.



Graph 2 shows the results for Healthcare Associated infections in 2021/22.



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

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

Covid Recovery - Background:

The COVID-19 pandemic has challenged the NHS in many different ways, including operational delivery, capacity and capability. The Trust will continue to ensure that a robust and proactive process for the management of waiting lists is in place to avoid unnecessary delays to clinical review and treatment potentially resulting in clinical harm.

Covid Recovery - How progress will be monitored, measured and reported:

Clinical Oversight Recovery Group.

Patient Safety and Clinical Effectiveness Sub-committee monthly.

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

COVID Recovery - Implementation and Performance:

The Trust achieved the revised 104 trajectory submitted to NHSEI.

The revised stretch target has been achieved in relation to the admitted and non-admitted targets following additional central funding.

The Trust will continue to prioritise the longest waiting patients and those of greater acuity and urgency (Urgent, P2 and long waiters) in line with local and national recommendations.

The Covid Recovery Programme is monitored via the Trusts Clinical Recovery Oversight Group which is chaired by a Non-Executive Director in addition to a Strategic Executive Oversight Group chaired by the Chief Operating Officer. Covid Recovery will remain a key focus as part of Quality Priorities for 2022/23. Detail of the Recovery Programme has consistently been shared with the CCG and the CQC.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR): Improve communication with family/patients with effective communication, documented discussion and inclusive decision making.

DNACPR Background:

Communication is fundamental in the decision-making process regarding the completion of a DNACPR form, for patients and how options and recommendations for DNACPR are discussed with patients, carers and their families.

DNACPR - How progress will be monitored, measured and reported:

Patient Safety and Clinical Effectiveness Sub-committee monthly.

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

DNACPR - Implementation and Performance:

- **Education and Training**
  - The new training on CPR Decision Making and Discussions continues at pace and feedback, including pre and post training confidence scores, is encouraging.
  - Following an SJR at MRG, encouraging feedback and valuable discussion were generated following a Grand Round focussing on identifying dying and decision making - evidence of cultural change has been noted.

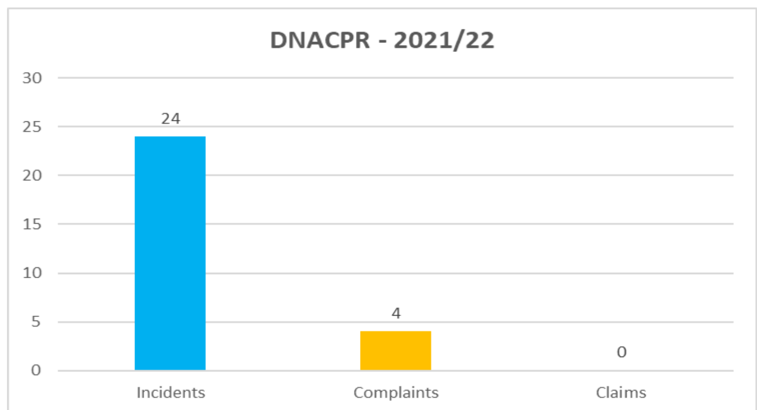
- **Documentation and Communication**
  - The new Lorenzo Form to document and prompt appropriate CPR Decisions and Discussions, encompassing treatment escalation planning and holistic, patient focussed end of life care planning has been launched
  - This will enable launch of the amended audit focussing on quality of the discussions which forms part of a Quality Improvement Project

- **Audit (including Audit of Quality)**
  - Audit of the uDNACPR forms shows increased compliance with all areas showing above 90% compliance.
  - A subsequent Audit will also include the MIAA recommendation that forms are verified by consultant/ associate specialist within 48 hours.
  - A Quality Improvement Project will focus on the implementation and changes following the new Policy and Lorenzo Form- namely quality of the decision, discussion and documentation, as well as access and filing of the paper forms.

- **Updated Policy**
  - The new Adult Cardiopulmonary Resuscitation (CPR) Decision Making Policy (which replaces the DNACPR policy) has been ratified at Policy Review Group on 26.1.2022 and has been launched on 15.2.2022.
  - This policy was welcomed by MIAA which recommended two included clarifications - that verification of uDNACPR forms by a consultant/ associate specialist should happen within 48 hours, and that there is a unified and recognisable filing system in all areas for completed uDNACPR forms.

- **Acute-Community Collaboration**
  - Collaborative plans are in development to improve early decision making and treatment escalation planning in the community.
  - There is support from community partners to progress to a ReSPECT process, discussions at CCG level regarding this remain ongoing.

The graph below identifies how many incidents, complaints and claims there were in 2021/22 relating to DNACPR.



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

Medical Examiner – embed the service across the acute setting and act as a pilot site for community roll out

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

The Medical Examiner System has now been embedded into the Trust since September 2020. Medical Examiners are part of a National Network of highly trained Independent Senior Doctors from any speciality who perform scrutiny of patient's who pass away both in Warrington and Halton NHS Foundation Trust, and the non-acute sector.

The Service is overseen by the National Medical Examiner, and Regional Medical Examiner. The Service scrutinises all deaths that are not reportable to H M Coroner, the Medical Examiner will discuss the care and cause of death with the Attending Practitioner, record any opportunities to share and learn from deaths and to improve the quality of the Medical Certificate of Cause of Death, in addition the bereaved family have an opportunity to ask questions or raise any concerns to an independent service.

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

Mortality Review Steering Group held monthly.

Mortality and Morbidity (M&M) meetings monthly

Patient Safety and Clinical Effectiveness Sub-committee held monthly.

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

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

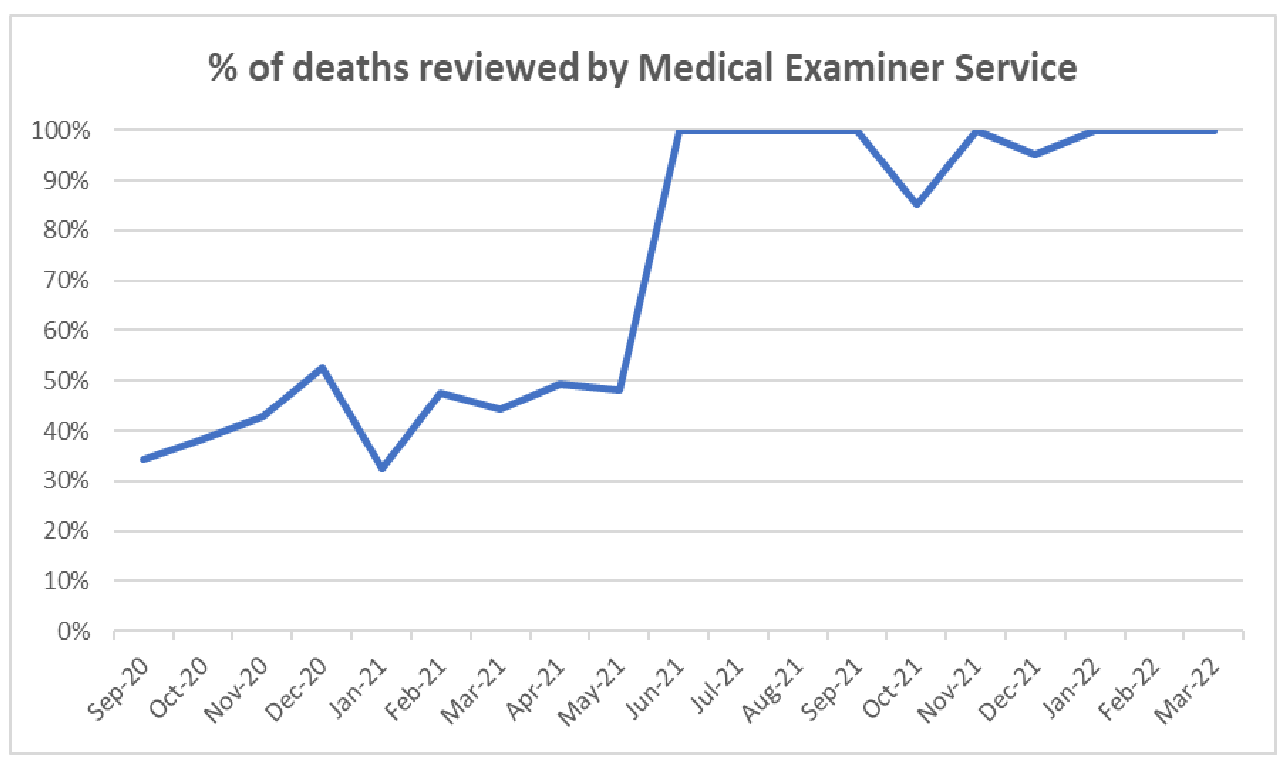
Sharing of this data with the Quality Assurance Committee and other relevant groups in the Trust.

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

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

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

Graph 1 below details the number of deaths scrutinised by the Medical Examiner(s) in 2021/22 from when the service was implemented in September 2020.



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

GIRFT and NICE - Background:

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

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

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

Patient Safety & Clinical Effectiveness Sub-committee

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

GIRFT and NICE - Implementation and Performance:

The COVID-19 pandemic has impacted upon the GIRFT Regional Implementation Teams ability to deliver planned works due to redeployment and subsequent redesign, which is outside of any Trust's control. In July 2021 NHS E/I launched the new GIRFT toolkit, a document that outlines best practice when implementing GIRFT within an organisation. The Trust's leads for GIRFT have outlined a proposal for the launch of the Trust's new GIRFT process which will be taken forward in 22/23.

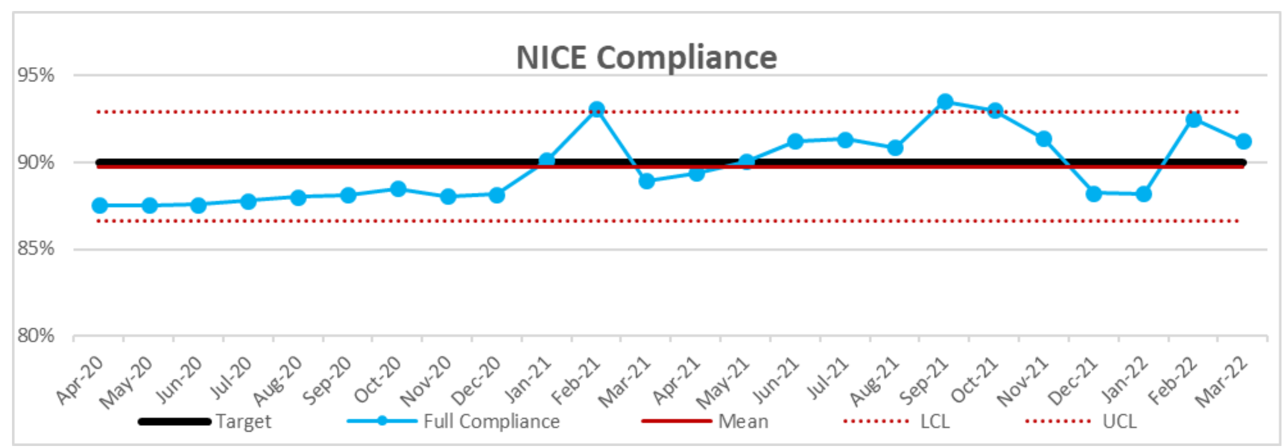
Most GIRFT activity by the regional NHS E/I teams has been paused, with the exception of two virtual reviews and one data request (details below):

- In October 2021 the NHSE/I GIRFT team undertook a virtual review of Urology services within the Trust and across the region. The Trust received positive feedback during the process and are awaiting the final report.
- In Trauma and Orthopaedics a virtual review was undertaken in October 2021, by virtue of submission of a survey. The Trust has received no further requests for information following this review and is currently awaiting the outcome. The outcomes for these reports have been delayed due to the pandemic.
- A further dataset was submitted to NHSE/I for high volume, low complexity surgery to support the GIRFT Demand and Capacity waiting list workstream in February 2022.

Throughout 2021/2022 the national GIRFT programme continued to analyse data and provide GIRFT national speciality reports which have been shared with all specialties. The national reports have provided a useful benchmark until the full programme recommences, which have been shared at local governance meetings.

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

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



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

CBU Governance to be strengthened - Background:

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

How progress will be monitored, measured and reported:

Patient Safety & Clinical Effectiveness Sub-committee

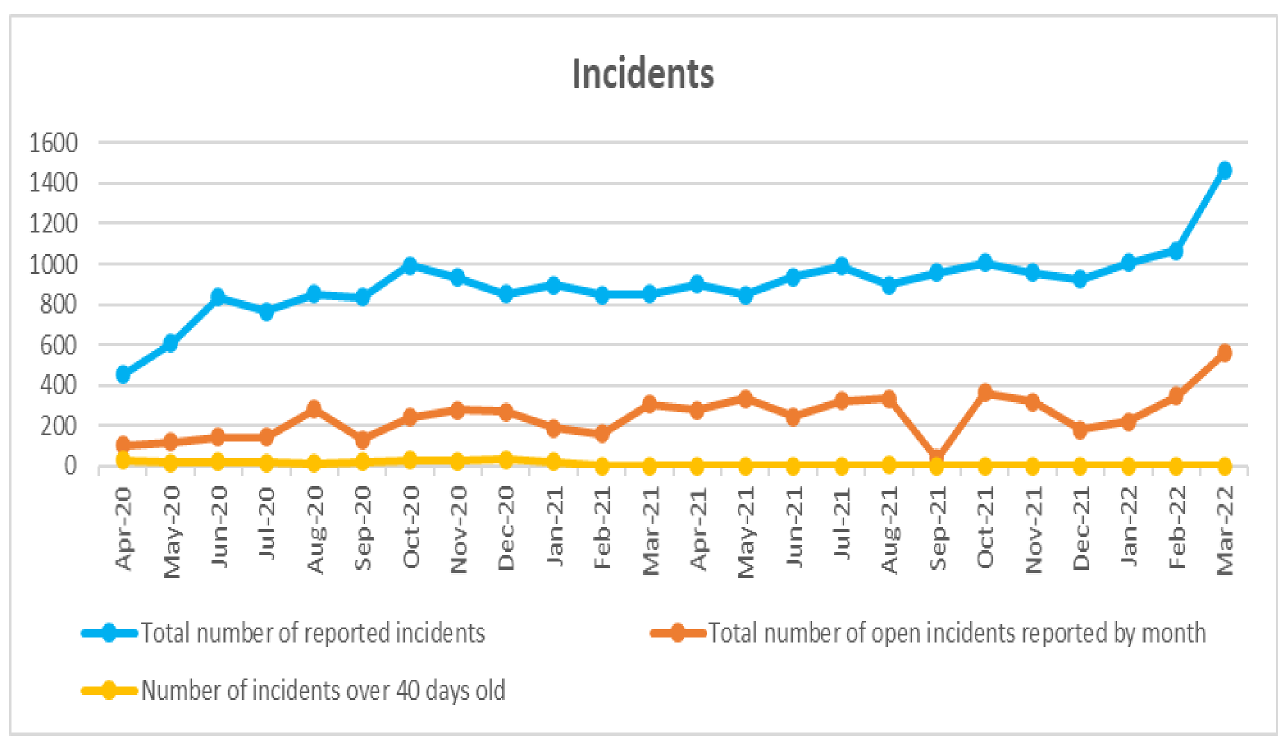
CBU Governance to be strengthened ensuring consistency across the organisation. Clinical governance aims to shift the performance of all health organisations closer to the standards of the best. It hopes to reduce unjustifiable variations in quality of care provided.

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

CBU Governance to be strengthened - Implementation and Performance:

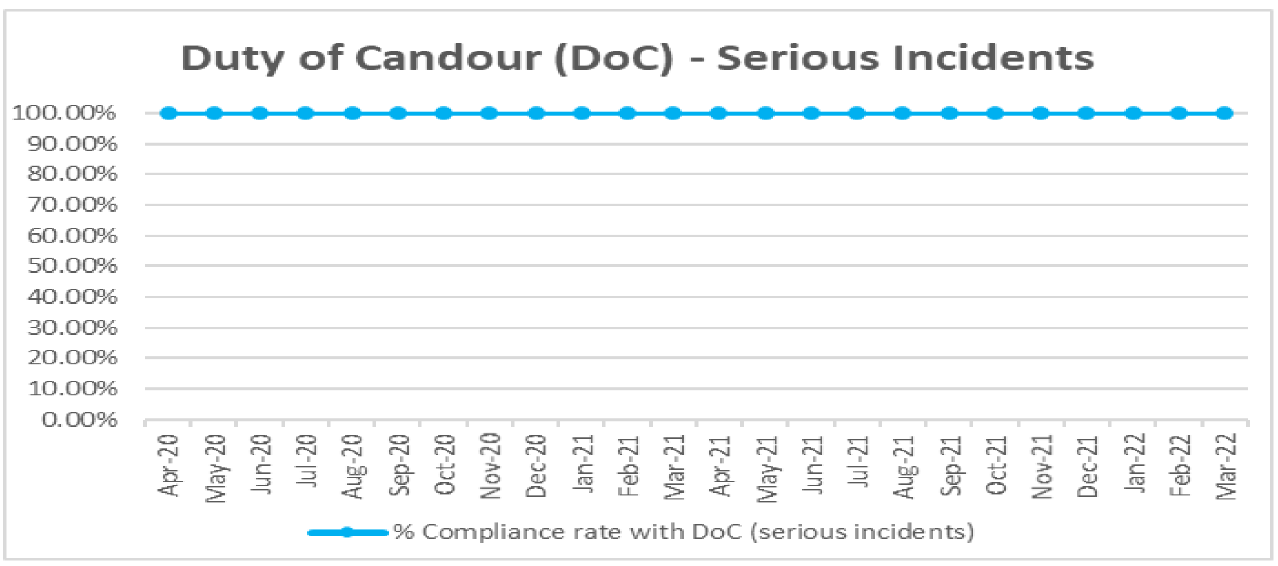
Incidents

The data demonstrates that the Trust has a positive culture of incident reporting as indicated in the graph below. There is robust monitoring of grading of incidents to confirm validation of the level of harm. In addition, incidents are monitored weekly via the governance framework.



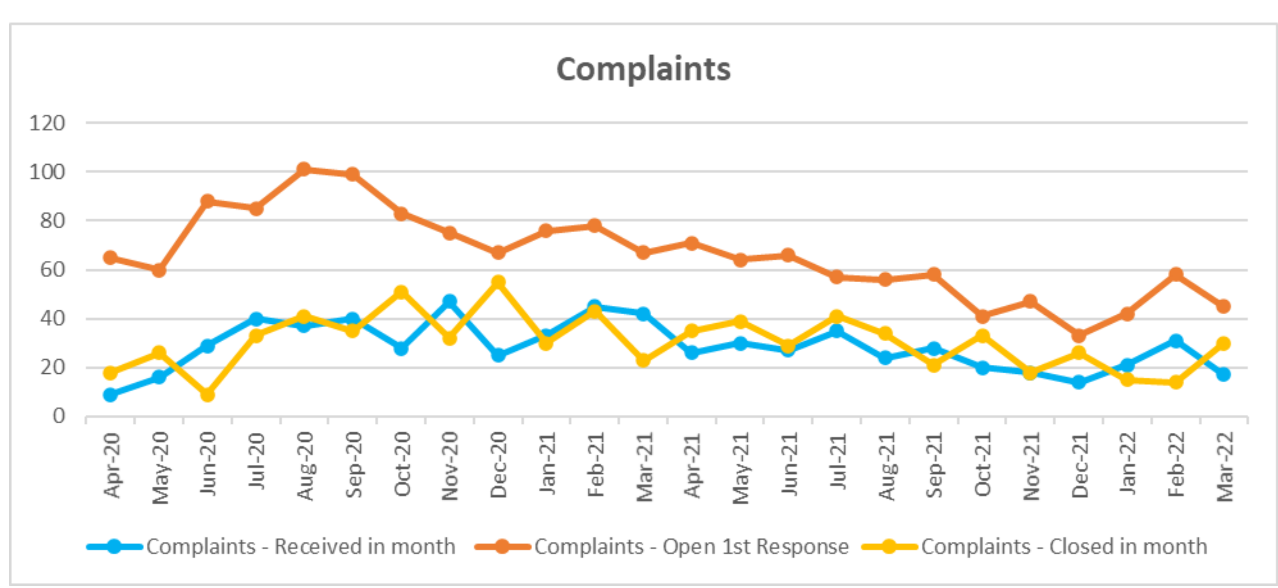
Duty of Candour

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 are had.



Complaints

A key focus has been to reduce the number of formal complaints in order to optimise patient or relative experience. This is evidenced through the number of complaints received. The table below notes the number of complaints opened and closed. This increase in performance is largely attributed to engagement from each of the CBUs to support with timely resolution and focus on the quality of responses provided. All complainants are initially offered a meeting with the relevant teams to facilitate a supported approach.



Risk Management and Governance

A key focus was to review risk management within the Trust to ensure the following:

- The risk processes and risk registers are continually monitored by the CBU Governance meetings and the Trust monthly Risk Review Group.
- Risk registers are updated regularly and kept in date.
- There is a positive and open risk management culture throughout the Trust.
- Staff are aware of the process for the management of risk at a local and Clinical Business Unit (CBU) level.
- Identification of any training needs i.e., Risk Assessment Training.
- Planned training is in progress for 2022 via formal risk management training.

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

Improve patient experience by enhancing the standard of nutrition and hydration

Work has continued to ensure the delivery of the recommendations outlined in the "Independent Review of NHS Hospital Food" report, although COVID-19 and operational pressures have impacted on delivery timescales. This is monitored via an action plan at the WHH Expert Food Panel, ensuring that hydration and nutrition continue to remain an integral element of the patient experience quality priorities for 2021-22.

The Expert Food Panel following a review of its Terms of Reference convenes in a multi-disciplinary approach to ensure that through discussion an inclusive style is adopted. This triangulates into an action plan that focuses on improvements in patient care, wellbeing and experience.

The expert food panel adopted a three-phase approach to drive improvements in nutrition and hydrations, they include:

- **Phase 1 –** A communication piece to ensure all wards and departments are aware of 'the offer' to patients' meals, this includes the process to follow for supplementary menus and special diets, e.g., cultural requirements. This is currently ongoing into quarter 4 with a standard operating procedure (SOP) being designed for the service of food at ward level.
- **Phase 2 –** Review of the current catering questionnaire to gain qualitative feedback from patients. This includes the implementation of questionnaires in accessible formats (e.g., Easy Read) to ensure feedback is received from all patient groups.

- **Phase 3 –** Begin to utilise feedback received through phase 2 to enhance the Expert Food Panel action plan to meet improvements, with the patient voice driving change.

The National Adult Inpatient Survey 2020 results highlighted focused improvement is still required on nutrition and hydration. The quantitative findings and subsequent comments report have been incorporated into the action plan for the Expert Food Panel and further details related to dietetics will be shared through the Trust Nutritional Steering Group by the Patient Experience and Inclusion Team.

Additional progress to date against the action plan in place includes:

- Patient nutritional and hydration needs is a standing item on key meetings within the Trust including the Patient Experience Sub Committee.
- Review of the Catering Policy
- A 1.8million capital bid has been secured in order to upgrade the kitchen on the Warrington site.
- The introduction of snack boxes for adults and "pizza take out" for children's ward to support patient choice.
- Food tasting with key stakeholders – Board members, Governors, Patient Experience and Inclusion Team to support ongoing improvements.

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

End of Life Serious Illness Programme Background:

The Serious Illness Care Programme - Better Communication, Better Care - is a system-level intervention designed to improve the lives of people with a serious illness by optimising the timing, frequency, and quality of serious illness conversations.

Comprising clinical tools, training, support, and systems innovations, the programme empowers patients to actively participate in planning for the future with their illness. It enables clinicians and other professionals in the wider healthcare system to personalise care according to the goals and priorities of individual patients.

Effective communication is key to ensuring that a patient feels empowered to input into their healthcare needs and to ensure that they understand the discussion that has taken place.

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

End of Life Care Steering Group Monthly

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

End of Life Serious Illness Programme - Implementation and Performance:

Due to staffing pressures relating to the COVID-19 pandemic, this priority has not progressed.

Learning Disability Strategy and Mental Health Strategy - Implementation of the Trust Learning Disability Strategy.

Learning Disability and Mental Health Strategy Background:

Implementation of the Learning Disabilities Strategy aspires to ensure that the needs of people with learning disabilities and autism are met to the highest standard, optimising clinical outcomes and patient experience.

Implementation of the Trust Mental health strategy will evidence that dedicated mental health and psychology provision as part of an integrated service can substantially reduce poor health outcomes and increase the quality of Mental Health Act provision.

Learning Disability and Mental Health Strategy: How progress will be monitored, measured and reported:

- Safeguarding Committee.
- Patient Safety & Clinical Effectiveness Sub-committee
- Quality Assurance Committee.
- Patient experience survey

Learning Disability and Mental Health Strategy: Implementation and Performance:

WHH has a Learning Disability Strategy and Mental Health Strategy in place to ensure the delivery of safe care for our patients, optimising health outcomes.   This is a three year strategy and implementation will continue in 22/23 as part of the Trusts focused work on Quality Priorities.

The strategy has been supported by training opportunities to support staff in the delivery of care at levels 1, 2 and 3. The training compliance is ahead of trajectory with positive evaluation. Areas across the Trust are supported through LD and MH champions who disseminate learning and offer specialist advice.

- WHH has also introduced Makaton Monday weekly sessions which are provided via the Trust Wide Safety Brief. These have been well received.
- WHH has a robust alert system in place to ensure that patients with LD, MH challenges and autism are promptly identified through the EPR system enabling the provision and delivery of timely and specialist care as required. ICE notifications are also utilised to ensure Safeguarding support is sought for patients who are under the Mental Health Act. WHH continue to attend
- the Warrington LD board, the Cheshire and Merseyside LD Improvement Group, regional LD network and transition meetings, thus supporting wider learning for continual improvement.

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

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

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

2.4 Improvement Priorities for 2022/23

The Trust Board, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2022/23 will continue to be:

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

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

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

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

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.

Continue to develop models of waiting list management in line with national guidance ensuring appropriate clinical prioritisation.

1. Continue to undertake clinical triage process.
2. Continue to undertake harm review process.
3. Continue to report for assurance via Clinical Oversight Group and Quality Assurance Committee.

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 across the organisation in accordance with the requirements of the patient safety strategy and alterations to the investigation process utilising new methodologies.
2. Evidenced through the use of incident reporting, learning, risk management and triangulation of clinical governance.
3. Evidenced through implementation of a learning framework.

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.

To evidence a culture of quality, safety and learning across clinical services

1. Implementation and Audit of LOCSIP safety standards which apply to invasive procedures
2. Audit of WHO checklist effectiveness and with evidence of effective operative debriefs delivering effective learning, team culture and improvement.
3. Improve safety through delivery and evaluation of human factors training.

Discharge processes will be strengthened to improve the quality of discharge to home and community providers

1. Ensuring early measures are in place to facilitate timely discharge, improving length of stay with data presented by each ward.
2. Patients will be partners in their care through communication and information sharing, measured through survey feedback.
3. Plan for discharge from the point of admission with effective management of EDDs identified at Board rounds and high quality discharge summaries.

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.

Nutrition and Hydration – ensuring patients receive and are supported to optimise dietary and hydration needs.

1. Implement and monitor the action plan to deliver the outlined recommendations of the 2020 'Independent Review of NHS Hospital Food' report ensuring access to high quality food and choice supported by an independent industry expert.
2. To ensure all patients hydration needs are met and monitored in accordance with their health needs, utilising ward-based quality metrics.
3. Refresh and implement the Nutritional Care Strategy in collaboration with patients.

Ensure the Mental Health and Learning Disability Strategies are implemented Trust wide.

1. Audit the use of patient's passports by Care Group via the Learning Disability and Mental Health Steering Groups.
2. Evidence effective and robust alert processes for the Trust EPR system.
3. Competency based training for Learning Disability, Autism and Mental Health to be available for all staff groups in the Trust.

Through patient centred communication and service development address inequalities for access to health.

1. Work with partners to support our population to access preventative and early intervention services specific to the needs of each person through the co-design of digitally enabled services.
2. Deploy and audit the accessible information standards policy across WHH.
3. Monitor and deliver against the First Impressions project – listening and improving the experience for patients, service users, their families, carers and our workforce.

2.5 Local Quality Indicators 2022/23

The Trust Board, in partnership with staff and Governors, has reviewed performance data relating to quality of care and have agreed that in addition to our improvement priorities our quality indicators for 2022/23 will include:

Local Quality Indicators 2022/23
CCG1: Flu vaccinations for frontline healthcare workers
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
CCG4: Compliance with timed diagnostic pathways for cancer service
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery
CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service.
CCG8: Supporting patients to drink, eat and mobilise after surgery
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients

2.6 Statements of Assurance from the Board

During 2021/22, the Warrington and Halton Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted seven relevant health services.

The Warrington and Halton Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the NHS services reviewed in 2021/22 represents 100 per cent of the total income generated from the provision of relevant health services by the Warrington and Halton Teaching Hospitals NHS Foundation Trust for 2022/23.

2.7 Data Quality

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

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

2.8 Participation in National Clinical Audits and National Confidential Enquiries 2021/22

During 2021/2022, **31** National Clinical Audit Programmes covered relevant health services that Warrington and Halton Teaching Hospitals NHS Foundation Trust provides. The National Clinical Audits Warrington and Halton Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2021/22 were as follows: -

HQIP ID	National Clinical Audit	Participated	Data Collected	Stage / Number / or % of cases submitted 2021/2022
1	Case Mix Programme (CMP)	Yes	Yes	100% (871)
3	Chronic Kidney Disease registry	Yes	Yes	100%
5	Elective Surgery - National PROMs Programme	Yes	Yes	EuroQol-visual analogue scales (EQ VAS) modelled records for 2020 Hip replacement primary 89 - not an outlier Hip replacement revision 3 (insufficient records) Knee replacement primary 127 - not an outlier Knee replacement revision 3 (insufficient records) Total Hip replacement 92 - not an outlier Total knee replacement 132 - not an outlier
6	Emergency Medicine QIPs: Pain in Children	N/A	N/A	Audit did not run
6	Emergency Medicine QIPs: Severe sepsis and septic shock	N/A	N/A	Audit did not run
7	Falls and Fragility Fractures Audit programme (FFFAP): National Audit of Inpatient Falls	N/A	N/A	Audit did not run
7	Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	Yes	Yes	100% (333)
8	Inflammatory Bowel Disease (IBD) Registry	Yes	Yes	Ongoing data collection 290 submitted
10	Maternal, New-born and Infant Clinical Outcome Review Programme	Yes	Yes	100% (20)
13	National Diabetes Audit: National Diabetes Core Audit	Yes	Yes	100% (1183)

HQIP ID	National Clinical Audit	Participated	Data Collected	Stage / Number / or % of cases submitted 2021/2022
13	National Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	Yes	100% (10)
13	National Diabetes Audit: National Diabetes Footcare Audit	Yes	Yes	Ongoing data collection 138 submitted
13	National Diabetes Audit: National Inpatient/Harms	Yes	Yes	Ongoing data collection 15 submitted
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit: Paediatric Asthma Secondary Care	Yes	Yes	Ongoing data collection 19 submitted
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit: Adult Asthma Secondary Care	Yes	Yes	Ongoing data collection 113 submitted
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit: Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes	Ongoing data collection 358 submitted
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit: Pulmonary Rehabilitation-Organisational and Clinical Audit	Yes	Yes	Ongoing data collection 18 submitted
15	National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Ongoing data collection 210 submitted
16	National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	Ongoing data collection 669 submitted
19	National Audit of Dementia	N/A	N/A	Audit did not run
21	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	Ongoing data collection 49 submitted
22	National Cardiac Arrest Audit (NCAA)	No	No	WHH formally withdrew from the National Cardiac Arrest Audit due to Covid-19 pressures.
23	National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management	Yes	Yes	Ongoing data collection 219 submitted
23	National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project	Yes	Yes	Ongoing data collection 516 submitted
23	National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Yes	Yes	Ongoing data collection 478 submitted
26	National Comparative Audit of Blood Transfusion:	No	No	WHH did not participate due to

HQIP ID	National Clinical Audit	Participated	Data Collected	Stage / Number / or % of cases submitted 2021/2022
	2021 Audit of Patient Blood Management & NICE Guidelines			Covid-19 pressures.
26	National Comparative Audit of Blood Transfusion: 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery			Audit did not run
27	National Early Inflammatory Arthritis Audit	Yes		Data collection has just been reinstated
28	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Ongoing data collection 124 cases submitted
29	National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer	Yes	Yes	<65% - our case ascertainment figure is currently being reviewed by NHS Digital
29	National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit	Yes	Yes	Ongoing data collection 83 submitted
30	National Joint Registry (NJR)	Yes	Yes	97.7% better than expected (664)
31	National Lung Cancer Audit (NLCA)	Yes	Yes	WHH does not perform surgery, but does refer patients to the Royal Liverpool surgical unit: There were 423 surgical resections in the 2018 cohort
32	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100% (2075)
33	National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100% (422)
34	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Ongoing data collection 137 submitted
36	National Prostate Cancer Audit	Yes	Yes	Ongoing data collection 119 submitted
42	Respiratory Audits: National Outpatient Management of Pulmonary Embolism	Yes	Yes	100% (17)
42	Respiratory Audits: National Smoking Cessation 2021 Audit	Yes	Yes	100% (20)
43	Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	80-89% Cases Q1 2021 band A
44	Serious Hazards of Transfusion	Yes	Yes	100% (4)
47	The Trauma Audit & Research Network (TARN)	Yes	Yes	83% better than expected (212)

HQIP ID	National Clinical Audit	Participated	Data Collected	Stage / Number / or % of cases submitted 2021/2022
48	UK Cystic Fibrosis Registry	Yes	Yes	100% (26)

National Confidential Enquiries

During 2021/22 there were 7 NCEPOD studies, of which WHH were eligible to participate in the following 5:

	National Confidential Enquiries
1	Heart Failure
2	Alcohol related Liver Disease
3	Pulmonary Embolism
4	Epilepsy
5	Out of Hospital Cardiac Arrest

2.8.1 National Clinical Audit

The reports of 13 National Clinical Audits were reviewed by the provider in 2021/2022 and Warrington and Halton Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit Title	Quality Improvement Action Plan
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme. 2021 data	4 relevant incidents were identified as categorised below using the SHOT reporting categories: **1x Right Blood, Right Patient** Compatibility labels on the blood units transcribed during issue in lab, error not detected when blood collected from Blood Bank and noticed only by 2nd checker on the ward. No harm, as right blood but incorrect donation number on label. Action: • Labels 2nd checked in lab before blood placed in Blood Bank • Emphasised requirement to check donation number on collection from Blood Bank when training staff • Emphasise 2nd check on wards during training, using this

National Audit Title	Quality Improvement Action Plan
	as an example **1x ADU (Avoidable, Delayed, Under/Over Transfused)** Blood not prescribed on mls/kg/body weight basis for a paediatric patient. Doctor prescribed 1 unit, unaware that Warrington does not use paediatric blood packages on site and uses adult volume RC. Action: • Prescriber informed and reflection undertaken • Policy and documentation checked to ensure need for correct calculation is clearly stated • Incident used as part of regular paediatric Doctor training sessions **1x Procedural Error** Failure to detect immune Anti-D resulting in the failure to monitor a pregnancy for Haemolytic Disease new-born Action: • Procedure for analysis and monitoring of anti-natal clinic samples changed to prevent recurrence • Learning disseminated to relevant departments **1x HSE (Handling and storage error)** Blood in blood transport box for 5 hours. Box should only be used for transport from Blood Bank to bedside for immediate transfusion with a timer set for 30 mins from Blood Bank removal • Emphasised limitations of the blood boxes at ward huddles
National Maternity and Perinatal Audit (NMPA) 2017-2018 data	• Undertake an Induction of labour audit (against NICE guidelines) • Evaluate Vaginal birth after caesarean birth (VBAC) service
National Paediatric Diabetes Audit (NPDA) 2019-2020 data	• Improvement required in training patients for carbohydrate counting at diagnosis. Participate in Royal College of Paediatrics and Child Health (RCPCH) Quality Improvement study • Increase uptake Diabetes eye screening (Needs communicating to patients at annual screen in clinic visits and escalate to community lead for Diabetes retinal screening lead) • Ensure improved monitoring for coeliac screening at diagnosis (raise awareness with juniors at induction and monitoring by Paediatric Diabetes Specialist Nurse after discharge)
National Audit of Breast Cancer in Older People (NABCOP) 2014-2018 data	• Complete an audit of reoperation rates after breast conserving surgery
National Audit of Cardiac Rhythm Management (CRM) 2019-2020 data	• Data completeness greater than 95%. • Centre activity recorded was as expected • Operators consistently doing more than the minimum

National Audit Title	Quality Improvement Action Plan
	requirement of pacemaker implantation per year, • 100% compliance with NICE (TA324 and TA 88). • No actions required
Adult Asthma (NACAP) 2019-2020 data	• Establish a specialist Asthma Advanced Nurse Practitioner • Establish an Asthma Lead • Introduce a comprehensive referral system into the severe asthma clinic on Lorenzo clinical assessment templates • Set up specialist Asthma clinic for Fractional exhaled Nitric Oxide (FENO) testing as per NICE
National Joint Registry (NJR) 2019-2020 data	• National audit confirms better than expected for compliance, revision compliance and accuracy of data entry • Hip: Patient reported improvement measure and outcomes quality measure, within the expected range. High compliance (98%) with NICE primary recommended implants • Knee: Patient reported improvement measure and outcomes quality measure within the expected range. • The only action required was to invite patients to consent to information being shared with the NJR
Maternal, New-Born and Infant Clinical Outcome Review Programme (MBRRACE) - Maternal Deaths 2016-2018 data	• To undertake a documentation audit looking at smoking rates, intended place of birth at booking and expected date of delivery
Myocardial Ischaemia National Audit Project (MINAP) 2019-2020 data	• To improve access to angiography by ensuring ongoing communication with Liverpool Heart and Chest Hospital
National Diabetes Inpatient Audit (NaDIA) 2019 data	• Hypoglycaemic rescue and Diabetic Keto acidosis was appropriately treated. • No hyperosmolar and Diabetic new foot ulcer cases reported within the audit periods • No actions required
Non-Invasive ventilation (NIV) 2018-2019 data	• Compliance with national NIV treatment guidelines • No actions required
Royal College of Emergency Medicine (RCEM): Mental Health 2019-2020 data	• Reinforce use of the mental health triage form in Emergency Department
National Diabetes Inpatient Audit (NaDIA) 2019 data	• Hypoglycaemic rescue and Diabetic Keto acidosis was appropriately treated • No hyperosmolar and Diabetic new foot ulcer cases reported within the audit period • No actions required

2.8.2 Local Clinical Audit

The reports of 74 local clinical audits were reviewed by the provider in 2020/2021 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Title of Audit	Action
Clinical Support Services	
Audit of Reporting of Liver Biopsies	• Double reporting of all liver biopsies by two Consultants at Warrington Hospital • Ensure clinicopathological correlation and communication with clinicians before authorising the report • The use of proformas for written liver biopsy reports
Administration of Blood Audit: Bedside Practice	• All Transfusions to be given through a pump
Applying the Paris System for Reporting Urinary Cytology	• To implement the Paris System as reporting standard for urine Cytology • To implement TPS as reporting standard for urine cytology
Audit of accuracy of Gentamicin Dosing Within WHH	• Promote use of Gentamicin calculator at Safety Brief
Clinical Audit to Review Prescribing and Administration of Medicines by Qualified Physician Associates at the Trust	• Inform the Educational Supervisors of instances of unauthorised administration in order that meetings can take place with the Qualified Physician Associates to review and support appropriate practice and future compliance with Standard operating procedure's • The Physician Associate Governance Framework to be re-circulated to all Qualified Physician Associates • Inform lead nurses for clinical areas regarding the need for witness signatures for medicines administered by Qualified Physician Associates • To review the current clinical supervision requirements for Qualified Physician Associates
Evaluating the Prevalence and Effectiveness of the Anticholinergic Burden (ACB) Score Reduction in Patients Admitted Following a Fall	• Create a ACB screening tool with IT to automatically calculate ACB to be used by pharmacists, pharmacy technicians, medical staff, and the frailty team & showcase to staff
Dental X-ray Quality Audit	• Information to be circulated to staff to help improve quality of technique and use of the correct image criteria • Staff to be emailed to ask, that when images will not allow clear annotations to be added and the Radiographer should add a sticky note on CRIS system (e.g., Position of intraoral, which images are open/closed)

Title of Audit	Action
Re-Audit of Compliance with WHH Lung Cancer Imaging Pathway	• Encourage Radiographers report directly and promptly to a Radiologist if they see an abnormality on a chest x-ray
Adequacy of Magnetic Resonance Imaging of the Shoulder Re-Audit	• Improvement in the coverage parameter as depicted by the European Society of Musculoskeletal Radiology (ESSR) guidance • Improvement in the use of correct imaging planes as depicted by the ESSR guidance • All patients must have their arms in the mid-external rotation if able
Re-Audit of Reporting Profiles in Cervical Biopsy Reporting	• Inform individual pathologists of their results) • Re-audit on a yearly basis
CT Dose Survey: Paediatric Head	• No actions required
Discrepancy Rates for Trauma CT Reporting at the Regional Radiology Hub	• Presentation at departmental audit meeting
Re-Audit of free foetal DNA (ffDNA) Compliance for RhD Negative Women During Pregnancy	• No actions required
Corporate Services	
7 Day Services Clinical Standard 2 Audit: Time to Consultant Review: 14 hours - Paediatrics	• Develop a Standard operating procedure (SOP) outlining which paediatric patients can be considered low-complexity, and thus not in need of consultant review
Discharge Summaries	• Discharge Summary teaching to FY1 doctors should draw on the findings of this audit; include examples of discharge summary completion on a mock patient on Lorenzo • Review Inpatient E-Discharge Summary form with IT team to enable higher compliance with completion • Liaise with Operational Safety Group and Discharge Planning improvement workstream to agree process for nursing discharge documentation • Disseminate key points at safety huddle at doctors' shift handovers • Link in with Discharge planning improvement workstream to coordinate improvement of the discharge process overall including timely completion of the Discharge Summary • Liaise with Medicines Improvement Group to improve discharge medication information and changes to medication information • Re-audit in 3 months with amended audit tool

Title of Audit	Action
Enhanced Care Audit	• Identify wards where compliance fell below expected standard to provide tailored support/education • Re-audit as per policy
Falls Policy Audit	• Repeat falls policy audit bi-yearly to monitor compliance • Trust wide falls walk rounds to be completed to highlight areas of concern/ share good practice
Fluid Balance	• Create new audit tool proforma • Create new fluid balance guidelines • Implement new fluid balance guidelines
Trust Wide Record Keeping Audit	• Share single point lesson on standards of record keeping with the ward managers for dissemination • Lead nurses to note the additional audit and progress in their HLBP until associated actions complete • Documentation audit & ward audit & associated actions to be shared at Governance meetings
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)	• No actions required
Digestive Diseases	
7 Day Services Clinical Standard 2 Audit: Time to Consultant Review: 14 hours - Surgery	• Develop a Standard Operating Procedure (SOP) to delegate review of certain categories of admission to the Surgical Registrars (such as head injuries, simple rib fractures and abscesses) • Facilitate a more user-friendly IT interface for doctors to a) become aware of time of decision to admit and b) easily document consultant reviews in real time
Management of Acute Cholecystitis, Gall Stone Pancreatitis and Biliary Colic During COVID-19 Pandemic.	• Extra weekend and evening cholecystectomy lists • Clinical priority coding to be introduced • Utilise a green surgical elective pathway • Increase awareness among surgeons to perform hot gallbladder on emergency list
Photo-documentation in Upper GI Endoscopy (Re-Audit)	• Present and make sure that endoscopists are aware of the updates from the British Society of Gastroenterology (BSG) guidelines
Post operative handover between the anaesthetist and Post Anaesthesia Care Unit (PACU) and the continued care of the patient in PACU ready for discharge to the ward	• Re-instate the sticker (cannula flushed) to be signed in recovery
Datix Reporting	• Departmental education about incident reporting system, how the system works
Antibiotic Prescribing for Acute Cholecystitis and Adherence to the Local Trust Formulary: An Audit in	• EPMA changes • Audit Presentation

Title of Audit	Action
Warrington Hospital	
TIVA Snapshot Audit	• No actions required
Integrated Medicine & Community	
A Re-Audit to Assess the Prevalence and Management of Pressure Ulcers and Moisture Lesions in Elderly Patients	• All nursing staff in wards B12 and B14, to have a small session in where the importance of documenting adequately in the individualised care plan must be emphasised (completed)
Pulmonary Embolism in COVID-19-19 Positive Patients Undergoing Computed Tomography Pulmonary Angiography (CTPA)	• No actions required
Medical Care	
An Audit to Assess the Recognition and initial management of Acute Kidney Injury (AKI) among medical admissions in Acute Medical Unit	• Educate the nursing staff regarding the importance of fluid balance, urine output monitoring • Implementation of AKI care Bundle in the trust policy
Audit of National Early Warning Score (NEWS) 2	• Decide at which point (in seniority) doctors and advanced clinicians such as Advanced critical care practitioners (ACP's) can make modifications to frequency/targets for physiological observations, adjusting the policy if indicated
Diabetic Inpatient Medication Errors	• Intensive Care Unit to use the same E-prescribing system as wards • Reinstate Diabetes Educator
Spot Audit Diabetic Inpatient Care	• Safety brief on the need to lock away insulin for inpatients
Seniority of Staff Undertaking Advanced Airway Management in Patients Suffering COVID-19-19 and Complications Arising	• No actions required
Your COVID-19 Recovery Website Usage for Management of Long COVID-19	• No actions required
Prescription of Medications in Acute Coronary Syndrome (ACS) Patients in the Acute Setting	• Follow the new order set completed to ensure timely prescription of ACS medications.
Surgical Specialties	

Title of Audit	Action
Audit on Thyroid Surgeries	• No actions needed – all British Association of Endocrine & Thyroid Surgeons (BAETS) standards met
Outcome Of Redesigned Paediatrics Referral Pathway	• Update wording on Health Visitor referral pathway to support triaging children < 2 years of age to a face-to-face clinic for their first appointment, if indicated
Quality standards for Neuro-Ophthalmology	• Review orthoptic-led neuro-ophthalmology guidelines and update on the Intranet Hub
Audit to Assess How Radiographs are Reported at Warrington and Halton Orthodontic and Maxillofacial Departments, March 2021	• Clinicians to start recording of the Quality Assurance grade of the radiograph they have requested • Improvement in compliance for examine the requested radiographs and record the findings in the patient's notes
Amblyopia Audit – Orthoptic Treatment Guidelines	• Update sbisa bar guidelines to be in line with British and Irish Optics Society (BIOS) guidelines
Atropine Audit: Compliance with local Guidelines and the Vision Outcomes of Amblyopic Children who are Treated with Atropine	• To create an amblyopia proforma/checklist to be used on Medisight
Are we Data Safe Whilst in Hospital	• Education – to spread the message via common email, IT Training and Stickers on Computers • Request support for IT Induction to be emphasising data security • Request Imprivata
British Orthopaedic Association Audit Standard for Trauma (BOAST) Ankle Audit	• Review and update department ankle fracture guidance by the foot and ankle team • Re-audit in 12 months as per BOAST guidance
Spinal Audit – Compliance with the Cauda Equina Pathway; 2nd Cycle	• All staff to be informed about the guidelines in the pathway via E-mail and • Clearly display pathway in Majors area • Presentation on Cauda Equina Neurological Examinations to be delivered • To clarify the GP referrals and SHOs to reiterate written handover from GP with neurological findings
Management and follow up of Patients with Ureteric Stents at WHH	• Ensure current literature from BAUS and EIDO are present on the hub to be provided on discharge • Re-audit once other actions are implemented
Hip & Knee Arthroplasty Surgery Documentation	• Share information required to document with all lower limb consultants so they can include in their operation note templates
COVID-19-19 Cases in Sir Tom Moore Building (formerly known as the Cheshire and Merseyside Treatment Centre)	• No actions required

Title of Audit	Action
New and Follow Up Head and Neck Cancer Patients During the COVID-19-19 Pandemic	• No actions required
Integrate COVID-19-19 Ears, Nose & Throat (ENT) Emergency Care Audit	• No actions required
COVID-19 Minor Trauma Snapshot	• No actions required
Compliance of Ophthalmology Local Safety Standard for Invasive Procedures (LocSSIPs)	• Redesign the Ophthalmology LocSSIP's in line with Trust standards • Send updated locSSIP for central logging of all Trust approved lOcSSIP's • Complete audit registration
Audit of Outcomes Following Surgical Revision of Dislocation of Primary Hip Arthroplasty.	• No actions required
Listing for Lower Third Molar Removal – Are We Conforming to the Norm Part 2 - Re-Audit	• No actions required
Microsuction of the Ear Canal as an Aerosol Generating Procedure (AGP)	• No actions required
Hot Joint Referrals to Trauma & Orthopaedics	• No actions required
Urgent & Emergency	
Review of standard 1 of the NICE Guideline CG143– Pain Relief for Patients Presenting with Acute Sickle Cell Crisis	• Inform staff of the pathway and for multimodal analgesia • Reiteration of pain scoring in triage • Organise a 'TED Talk' on Sickle Cell Crisis
The Management of Ankle Fractures Presenting to Warrington A&E	• To improve staff training and awareness of the immobility required in unstable ankle fractures by the development of a poster for presentation in the Minor Injuries Unit • A re-audit will then be performed to assess if this has been successful in reducing
WHH Adherence to Royal College of Emergency Medicine (RCEM) Standards of Care for Fracture Neck of Femur (#NOF)	• Discuss in safety brief & nursing huddle the importance of early analgesia for these patients. • To ensure training of all new Emergency Department Senior House Officers in Fascia Iliaca Block (FIB) application • Raise deficits in staffing in the Urgent Care meeting • Discuss addition of pain re-evaluation column into #NOF pathway in audit meeting

Title of Audit	Action
Pulmonary Embolus Audit	• Disseminate findings of poor Wells and Pulmonary Embolism Rule-out Criteria (PERC) scoring at audit meeting and safety briefs
Women & Children	
Post Operative Caesarean Section Analgesia	• Need to change prescribing set on Lorenzo in conjunction with E-prescribing lead and Pharmacy so Non-Steroidal Anti-Inflammatory Drugs (NSAID) are prescribed regularly • Discuss options with Pharmacy as this drug is not always needed but if so, prescription should be regular • Add laxative to prescription set
Audit of Continuous Antenatal Risk Assessment During the Maternity Pathway	• Spot check audits to be completed by midwifery managers to monitor improvement in compliance
Induction of Labour (IOL) 3-month Audit	• Produce a 1-page prompt sheet of reasons for IOL and appropriate gestations for IOL. This will be laminated and displayed in Ante natal rooms, Triage and Delivery Unit • Update the Trust IOL guideline with the new national RCOG guideline
Referral pathways to Out-Patient Hysteroscopy Service for intrauterine Contraceptive Device (IUCD) Insertion/Removal Audit	• Coil clinic to commence on a weekly basis, currently clinics are set up and ready for patients to be booked into
Injuries in Under 1's Presenting to the Emergency Department	• Guidance on injury in the non-ambulant child to be reissued and communicated
Intra Venous Fluids Therapy in Children and Young People in Hospital	• Review and update IV Fluids guideline (no major changes expected) • Ensure Fluid calculations and choices are on Induction Programme • Teaching session with nurses in meeting to empower nursing staff to question prescriptions • Review nurses Fluid Balance chart – add space for daily U&E and Glucose results
Management of Healthy Breast Fed Babies Admitted with Weight Loss	• Create referral pathway to Paediatric Acute Response Team for follow up of babies admitted with weight loss • Develop E-learning Tool to promote correct prescribing • Disseminate the audit finding to community midwives and nursing staff • Develop a proforma for new-born babies admitted with weight loss more than 10%
Maternity Safeguarding Note Audit	• Managers to share learning with staff via ward safety briefs to screen for domestic abuse at every opportunity and how document appropriately in the records

Title of Audit	Action
	• Senior managers to share in safety briefs reminding staff to add safeguarding stickers to records and how to apply a correct Lorenzo alert • All staff to attend domestic abuse training to ensure they are aware of how to screen, document and why this is required
Neonatal Cooling Treatment Audit	• Actions from the Healthcare Safety Investigation Branch (HSIB) recommendations monitored through CBU governance • Ensure robust system for timely follow ups for all cases is developed • Ensure appropriate local investigation for babies not investigated by HSIB • Update the Difficult Intubation Pathway
Paediatric National Early Warning Score (PEW's) and Escalation Audit	• Single point lesson through departmental newsletter to raise awareness regarding importance of documentation and escalation of PEWS chart by • Trust wide safety brief to be used to raise awareness about importance of using PEWS chart for recognising a sick child before they deteriorate
Meningitis Paediatric Patients Referred for Audiology Assessment	• No actions required
Infectious Diseases in Pregnancy Screening Programme	• No actions required
Fetal Anomaly Screening Programme	• No actions required
Diagnosis and Management of Meningitis	• Raise the awareness of the result among the nursing and medical staff • To include neonatal meningitis e-module for new doctors at induction

2.9 Participation in Clinical Research and Development

The number of patients receiving NHS services provided or sub- contracted by Warrington and Halton Teaching Hospitals NHS Foundation Trust in 2021/22 recruited to participate in research approved by a research ethics committee was 662. Please find these studies listed in the table below:

Study Type	Study Sponsor	Short Name	Study Title	Recruits
Commercial	VALNEVA	COV-COMPARE Immunogenicity of vaccine VLA2001 compared to AZD1222	A RANDOMIZED, OBSERVER-BLIND, CONTROLLED, SUPERIORITY STUDY TO COMPARE THE IMMUNOGENICITY AGAINST COVID-19, OF VLA2001 VACCINE TO AZD1222 VACCINE, IN ADULTS INCLUDING A RANDOMIZED, OBSERVER-	160

Study Type	Study Sponsor	Short Name	Study Title	Recruits
			BLIND, PLACEBO CONTROLLED PART IN ADOLESCENTS (~12 TO <18 YEARS)	
Commercial	SANOFI	Booster Dose of SARS-CoV-2 Vaccine with Adjuvant	Immunogenicity and Safety of SARS-CoV-2 Recombinant Protein Vaccines with AS03 Adjuvant in Adults 18 Years of Age and Older as a Primary Series and Immunogenicity and Safety of a Booster Dose of SARS-CoV-2 Adjuvanted Recombinant Protein Vaccines (two Monovalent and one Bivalent)	31
Non-Commercial	University of Oxford	Clinical Characterisation Protocol for Severe Emerging Infection	Clinical Characterisation Protocol for Severe Emerging Infection	346
Non-Commercial	NHS Lothian	GenOMICC	Genetics of susceptibility and mortality in critical care (GenOMICC)	18
Non-Commercial	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	The 'Big Baby Trial'	Induction of labour for predicted macrosomia	4
Non-Commercial	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	IBD-BOOST: SURVEY	What is the relationship between fatigue, pain and urgency in people with inflammatory bowel disease? The IBD-BOOST Survey	3
Non-Commercial	University of Oxford	Surgery or Cast for Injuries of the EpicoNdyle in Children's Elbows	SCIENCE Surgery or Cast for Injuries of the EpicoNdyle in Children's Elbows:A multi-centre prospective randomised superiority trial of operative fixation versus non-operative treatment for medial epicondyle fractures of the humerus in children.	1
Non-Commercial	King's College London	The PARROT-2 Trial	Placental growth Factor Repeat sampling for Reduction of adverse perinatal Outcomes in women with suspected pre-eclampsia	2
Non-Commercial	University of Oxford	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	2

Study Type	Study Sponsor	Short Name	Study Title	Recruits
			fractures in children.	
Non-Commercial	University of Oxford	RECOVERY trial	Randomised Evaluation of COVID-19 Therapy (RECOVERY)	21
Non-Commercial	Imperial College of Science, Technology and Medicine	Pregnancy and Neonatal Outcomes in COVID-19	Pregnancy and Neonatal Outcomes in COVID-19: A global registry of women with suspected or confirmed SARS-CoV-2 infection in pregnancy and their neonates, understanding natural history to guide treatment and prevention	8
Non-Commercial	Aston University	EnED- Education in Emergency Departments	Service Improvement Project to Learn from the Covid 19 Crisis and Plan Resilience for Future Peaks in Service Demand – Education in Emergency Departments – EnED	1
Non-Commercial	INTENSIVE CARE NATIONAL AUDIT AND RESEARCH CENTRE (ICNARC)	UK-ROX	Evaluating the clinical and cost-effectiveness of a conservative approach to oxygen therapy for invasively ventilated adults in intensive care.	9
Non-Commercial	LEEDS COMMUNITY HEALTHCARE NHS TRUST	National AHP Research RCC Survey	AHP perceptions of NHS research capability and culture: A national research capacity in context survey	16
			TOTAL	**622**

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

The Trust has been working with the National Institute for Health Research (NIHR), Clinical Research Network North West and Liverpool University Hospitals NHS Foundation Trust (LUHFT) to further develop its research and investigation capability. In 2020/2021 we were delighted to have commenced the first clinical trial, a COVID vaccine trial on Ward B1. The HCRU has since hosted a further covid19 vaccine trial with another to open in April 2022.

The unit was officially opened on Thursday 4th March 2021 by the Trust's Chairman alongside partners who form the Trusts Research Partnership Board. This partnership consists of LUFT and the Nort West Clinical Research Network. and has enabled both opportunity for staff and the local population to be provided with the opportunity to access clinical trials within the locality HCRU continues to provide flexible accommodation and staff to support different types of clinical research and trials. In its second year, the unit will continue to support covid19 studies but will also focus on expanding into other research areas, including vaccines for other diseases and paediatric medicine.

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

2.10 The CQUIN Framework

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

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

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

2.11 Care Quality Commission (CQC) Registration

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

The Care Quality Commission has not taken enforcement action against Warrington and Halton Teaching Hospitals NHS Foundation Trust during 2021/22.

The Trust is registered to provide the following services:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust has not been subject to any special reviews by the Care Quality Commission during 2021/22.

2.12 CQC Engagement

The Trust has not been inspected during 2021/2022. The CQC continued their regulatory approach using their Transitional Regulatory Approach with a focus on engagement meetings and assessments against the CQC's interim assurance frameworks. The CQC will launch a new regulatory approach in 2022/2023. Engagement meetings have continued throughout the reporting period with the CQC. In 2021/2022 the Trust has:

- Been assessed against the CQC's transitional regulatory approach for:
    - Maternity services
    - Urgent and Emergency Care
    - Trust-wide
- Commenced an internal programme of 'mock CQC inspections' with further inspections scheduled in 2022/2023.

Post CQC Inspection Activity

The post inspection action plan from the Trust's 2019 CQC inspection was completed in November 2020. The Trust has continued to focus on workstreams to support the Trust to 'Move to Outstanding', in line with our Moving to Outstanding Sub Committee which meets monthly. This reports into Quality Assurance Committee ahead of Trust Board.

2.13 Trust Data Quality

Warrington and Halton Teaching Hospitals NHS Foundation Trust submitted anonymised clinical data for patients seen and treated during April – February 2021/22* to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics.

The percentage of records in the published data which included the patient's valid NHS Number will be updated at the end of April 2022 when the national data is available.

National Data Set	Trust Valid	National Average Valid	Date Range
Admitted Patient Care	99.90%	99.70%	Apr 2021 – Feb 2022
Outpatient Care	100.00%	99.80%	Apr 2021 – Feb 2022
A&E Care – Type 1	98.90%	98.90%	Apr 2021- March 2022
A&E Care – Type 3	87.70%	87.70%	Apr 2021 – March 2022

The percentage of records in the published data which included the patient's valid General Medical Practice Code will be updated at the end of April 2022 when the national data is available.

National Data Set	Trust Valid	National Average Valid	Date Range
Admitted Patient Care	100%	99.70%	Apr 2021 – Feb 2022
Outpatient Care	100%	99.60%	Apr 2021 – Feb 2022
A&E Care – Type 1	99.50%	99.50%	Apr 2021- Mar 2022
A&E Care – Type 3	96.00%	96.00%	Apr 2021 – Mar 2022
*Data source provided from SUS – Cumulative year to date to Feb 2021/2022			

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.

2.14 Information Governance

The Trust uses the Data Security and Protection Toolkit in conjunction with the Datix Risk Management system to inform the work of its Information Governance and Records Sub-Committee. The Information Governance and Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the Trust Board.

The Trust's Senior Information Risk Owner (SIRO) chairs the Information Governance and Corporate Records Sub-Committee which is also attended by the Trust's Caldicott Guardian. The SIRO (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 targeted with action plans to ensure that we continue to strive to be information governance assured. In 2021 the Trust was the subject of a two-part Data Security and Protection Toolkit review conducted by Mersey Internal Audit Agency (MIAA). 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 2 of the review conducted by MIAA was comprised of an assessment against the National Data Guardian's 10 data security standards. The assurance level awarded across all 10 data security standards was moderate. The moderate assurance rating was awarded on the basis that no standards rated as unsatisfactory, and none rated as limited. The Trust's compliance with 7 of the 10 domains within the NDG standards were rated as substantial with three rated as moderate.

2.15 Clinical Coding/Payment by Results (PBR)

Nationally, Payment by Results was temporarily replaced by block contract arrangements from the start of the pandemic for financial years 2020/21 and 2021/22. These arrangements have continued into 2022/23.

There is a national shortage of experienced qualified Clinical Coders making recruitment challenging with vacant posts being recruited to with Trainees. Trainees can take between 3 – 5years to qualify and gain appropriate experience. There is, however, a plan in place which is improving the recruitment and retention of good quality staff to support up to date coding and further improvements to the quality of clinically coded data.

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

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

2.16 Learning from deaths

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

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

The Trust has currently trained 8 clinicians in the Royal College of Physicians Structured Judgment Review (SJR) method for recording deaths, mortality reviews and their outcomes, a further 4 clinicians are currently being trained. The Trust has developed an electronic system which logs Structured Judgement Reviews (SJR) electronically and triangulates findings with complaints, claims, inquests and incidents. This facilitates richer learning across the Trust.

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

By 31st March 2021, 203 SJRs were completed. 9 investigations (Serious Incidents) were carried out in relation to 1100 of the deaths. They occurred in each quarter of that reporting period as follows:

- Quarter 1 - 60 SJRs completed and 2 Serious Incidents.
- Quarter 2 – 33 SJRs completed and 0 Serious Incidents.
- Quarter 3 - 77 SJRs completed and 2 Serious Incidents.
- Quarter 4 – 52 SJRs completed and 5 Serious Incidents.

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

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

Due to the COVID-19 Pandemic the Learning from Deaths event and Patient Safety Summit to share learning over the past 12 months had to be paused. This will be reconvened in 2022.

2.17 Core Quality Indicators 2021/22

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

Where the necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed with:

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

Trusts are only required to include indicators that are relevant to the services they provide.

2.18 Summary Hospital-Level Mortality Indicator (SHMI)

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

DATE PERIOD		TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
01 November 2020 – 31 October 2021 At the time of writing this report this is the most recent data		98.26	2	118.60	71.93	100
November 2019- October 2020		106.9	2	117.75	67.82	100
November 2018 - October 2019		106.89	2	120.12	68.48	100
October 2018 – September 2019		105.93	2	118.77	69.79	100
October 2017 – September 2018		109.92	3	126.81	69.17	100
July 2016 – June 2017		112.32	2	122.77	72.61	100
NB: This information is re-based so there may be a variation from HED monthly reporting and details the 2020/201 national comparative data available at present.						

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

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, in that this is a nationally accepted dataset, which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data (HED) benchmarking system to facilitate further analysis. Trusts are banded 1-3 as follows:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust were categorised 'as expected' over the past 12 months.

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust-level across the NHS in England. This indicator is produced and published quarterly, as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die at the Trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures. A number below 100 indicates fewer than the expected numbers of deaths, and a number above 100 would suggest a higher than expected number of deaths.

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

We share learning from the Mortality Review group using the Mortality and Morbidity (M&M) meetings which are an opportunity for peer review, collective learning and quality improvement. These are held across all CBU's on their allocated audit days. Mortality and morbidity meetings are a professionally accountable forum based on sound educational principles. They encourage openness, honesty and transparency from participants. They focus upon learning and improvement of systems and processes of care and not on individual performance.

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

1. DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
01 November 2020 – 31 October 2021 At the time of writing this report this is the most recent data	55%	39%	64%	11%
November 2019- October 2020 NB:	45%	36%	59%	8%
November 2018 - October 2019	41%	36%	59%	11%
October 2018 – September 2019	40%	36%	59%	12%
October 2017 – September 2018	34.3%	33.4%	59.5%	14.3%
July 2016 – June 2017	41.7%	31.1%	58.6%	11.2%
https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/palliative-care-coding				

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset which is submitted to the

Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data benchmarking system to facilitate further analysis.

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

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

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

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

Data is being prepared and will be updated by then end of April 2022.

		Groin hernia	Hip replacement	Knee replacement
Year	Level	Average health gain	Average health gain	Average health gain
2020/21		*		
2019/2020	Trust	*	0.474	0.353
2019/2020	England	*	0.459	0.335
2018/2019	Trust		0.500	0.324
2018/2019	England		0.456	0.336
2017/2018	Trust	0.019	0.341	0.312
2017/2018	England	0.089	0.488	0.345
2016/2017	Trust	0.036	0.455	0.370
2016/2017	England	0.086	0.444	0.324

*2021/2022 and Groin hernia information for 2019/20 or 2020/10 data is not available at the time of reporting.

https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that the PROMs data is a nationally agreed dataset. The data is collected, processed, analysed and reported to the Health and Social Care Information Centre by a number of organisations, including hospital Trusts which perform PROMs procedures. PROMs calculate the health gains after surgical treatment, using pre- and post-operative surveys. The Health and Social Care Information Centre is responsible for scoring and publishing of PROMs data, as well as linking it to other

data sets such as Hospital Episodes Statistics. In 2022/23 this will be monitored via the Patient Experience Sub-Committee.

2.21 Emergency readmissions to hospital within 28 days of discharge

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

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

0 to 15; and

16 or over,

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

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

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

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

DATE	TRUST	ACUTE TRUSTS
2021*	64%	*Currently awaiting national results from 1st April 2022*
2020	71.3%	74.3%
2019	65.2%	70.5%
2018	60.7%	71.2%
2017	59.5%	70.6%

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

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

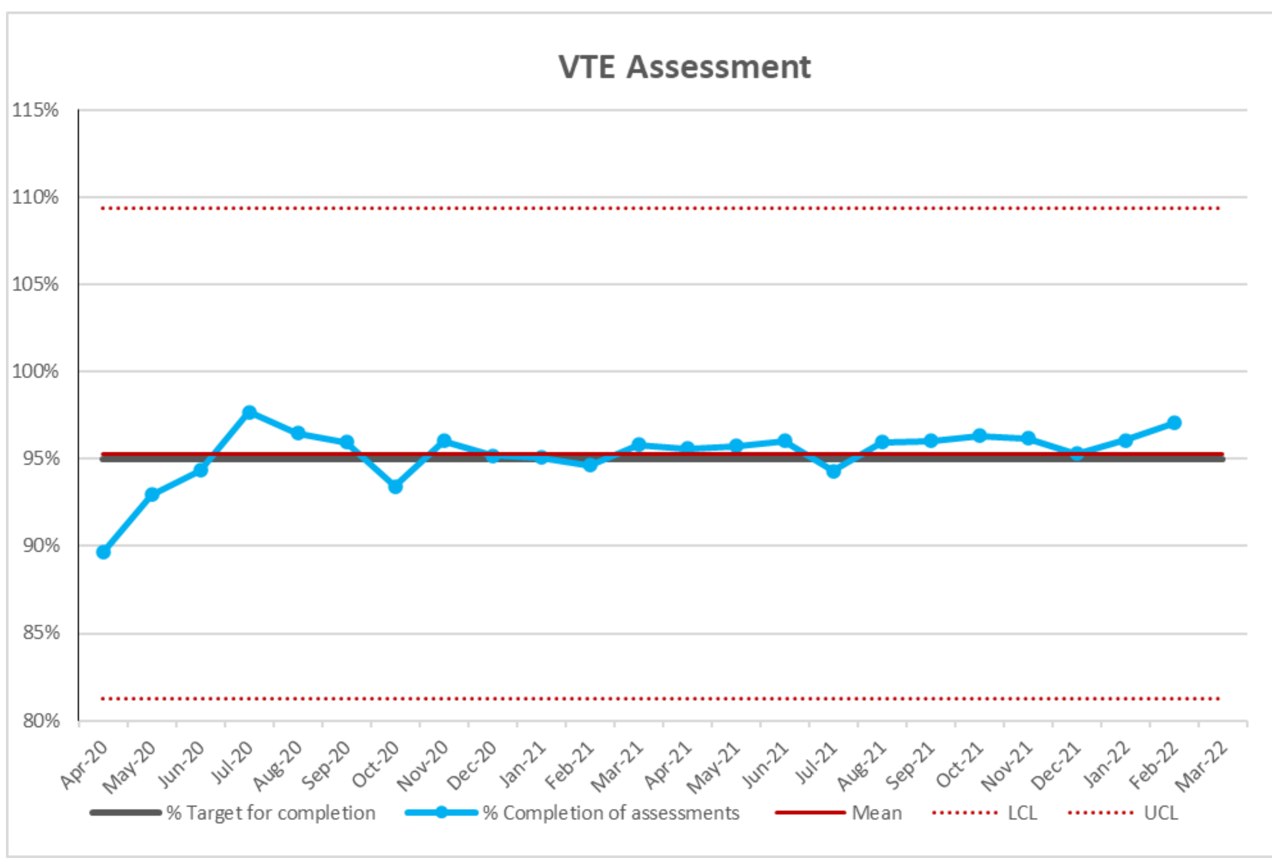
Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2021 national NHS staff survey conducted by Quality Health on behalf of the Trust. Quality Health utilises high quality research

methodology and mixed method collection resulting in a 40.2% response rate which represents 1,744 staff responding to this survey.

The Trust has several workstreams in place to improve this score, utilising a range of Quality Improvement methodology to implement change via the Trust's Quality Academy and supporting improvements through collaborative working with the organisation's People Champions and Staff Networks.

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

The data made available to the National Health Service Trust or NHS foundation Trust by the National Commissioning Board with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period. There was a decrease in performance; however, this is now steadily increasing (see SPC below)



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

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

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

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

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

DATE	TRUST REPORTED CASES	RATE	RATE (all reported cases per 100,000 population)
2020/2021	The England data will be updated at the end of April 2022 when the national data is available.		
2019/2020	78	43.6	23.5
2018/2019	65	35.9	21.9
2017/2018	55	29.9	23.9
2016/2017	65	34.1	23.3
Data Source: 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 the data is as described for the following reasons there is a robust system for data entry and validation which ensures all cases are entered onto the Public Health England Data Capture System.

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

- Action plan in place to reduce Clostridium difficile
- Improvements to methods of investigation for Clostridium difficile cases
- Action plan in place to reduce MRSA and MSSA bacteraemia cases
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment

2.25 Patient Safety Incidents

Patient Safety Incidents – Rate of incidents per 1000 bed days

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

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

Patient Safety Incidents Severe Harm / Death

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

NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same Trusts.
NB - *National = Severe Harm and Death combined.

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

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

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

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

- Quarterly Governance Reports, including the Learning from Experience Report and Learning from Deaths Report.
- Trust wide safety alerts and notifications
- Safety briefings in clinical areas
- Amendments to policy
- Annual Safety Summits
- Daily Safety Huddles
- Trust wide Safety brief
- Monthly CBU and Specialty Governance Meetings
- Weekly CBU Governance Review Meetings between CBU Managers and CBU Governance Managers

2.26 Freedom to Speak Up (FTSU)

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

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

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

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

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

2.27 Seven Day Hospital Services (7DS)

NHS England and NHSI altered their methodology for assessing compliance with the Seven Day Services priority clinical standards which has allowed the Trust to focus on Clinical Standard 2 (CS2) of the 7 Day Services, which is Time to First Consultant Review, in Paediatrics and General Surgery as a quality priority.

Paediatrics

In 2020/21, Paediatrics achieved the required 90% compliance with the standard during the Quarter 3 and Quarter 4 audit. In order to test sustainability with the compliance achieved, a further audit for Clinical Standard 2 will be implemented during 2022/23.

The Paediatric team demonstrated that 41/75 patients were evaluated and discharged on the same day with patient evaluation prioritised to registrar or Consultant based on severity and complexity. Their interpretation was a need to prioritise same day discharge to maintain flow through the unit. They also allocated admitted patient review to Consultant or Registrar based on severity. Identification of low complexity cases not requiring Consultant review is a required action.

Both specialties also identified that a patients DTA in the early evening were more likely to miss the 14-hour review in the morning ward round and recognised the need to identify when patients are approaching the 14-hour window and to reinforce morning ward rounds.

Both teams recognise the importance of achieving timely consultant review and have evaluated the audit and implemented action plans.

General Surgery

In 2021/22, General Surgery achieved the required 92% compliance with the standard during the audit. In order to test sustainability with the compliance achieved, a further audit for Clinical Standard 2 will be implemented during 2022/23.

The 2021 audit was undertaken during a period where the Trust was experiencing significant flow pressures, reduced assessment area capacity and staffing pressures. Although both specialties did not achieve the CS2 benchmark the audit has identified areas of improvement.

For General surgery 8/39 patients had no Consultant review time recorded and were therefore identified as outside the 14-hour standard.

Both specialties also identified that a patients DTA in the early evening were more likely to miss the 14-hour review in the morning ward round and recognised the need to identify when patients are approaching the 14-hour window and to reinforce morning ward rounds.

Both teams recognise the importance of achieving timely consultant review and have evaluated the audit and implemented action plans.

Part 3

2. Review of Quality Performance

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

3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

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

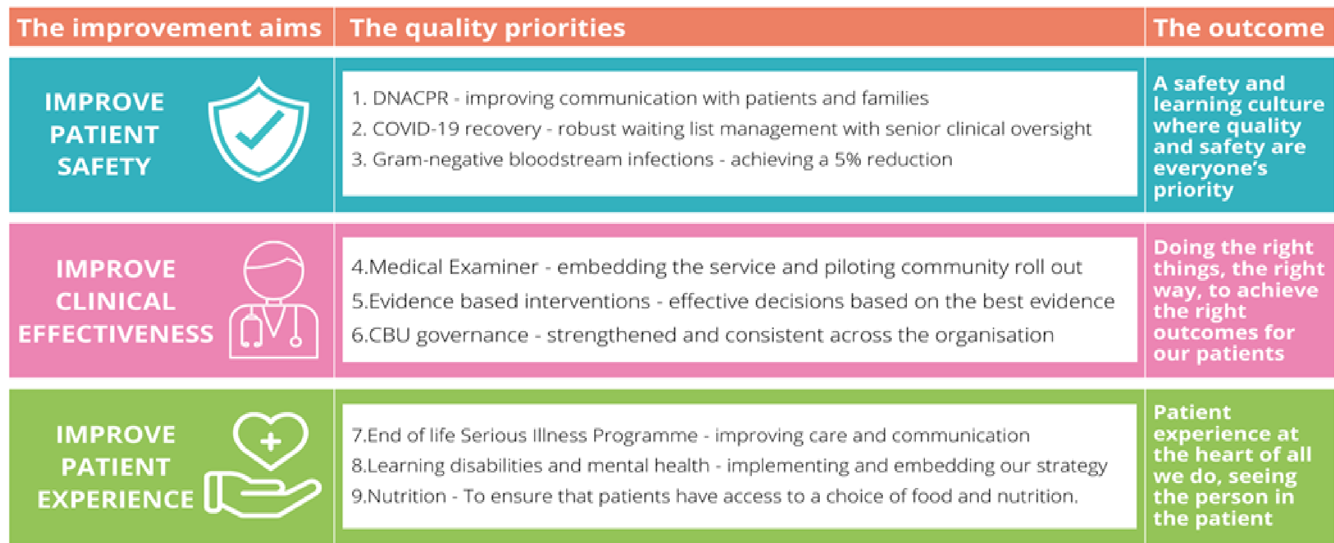
To support our overall aim, we have developed a Quality Strategy to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good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

The Quality strategy has been developed based first and foremost to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances;

and thirdly, to deliver an experience of hospital care which is as good as it possibly can be. With the above care model in mind, we use the following three priority domains:

3.2 Quality Strategy on a page

In year one of this Quality Strategy 2021/22, there are three priorities and nine new local quality indicators. Year one 2021/22 local quality indicators are listed below and detailed in the 'Plan on A Page' below.


OUR 2021–22 QUALITY PRIORITIES

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

3.3 Data Sources

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

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

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

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

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

3.4 Quality Dashboard 2021/22

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

- CQUINs – National (paused at present)
- NHSI KPI
- Quality Contract
- Quality Account - Improvement Priorities
- Quality Account – Quality Indicators

- Care Quality Commission
- Sign up to Safety – national patient safety topics
- Open and Honest

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

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

3.5 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the Trust based on performance in 2021/22 against a minimum of 3 indicators for each area of quality namely patient safety: clinical effectiveness and patient experience. These indicators were selected by the Board in consultation with stakeholders and discussions with the Quality in Care Committee of the Council of Governors. In the main, the Trust has employed indicators which are deemed to be of local and national importance to the quality of care for patients.

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

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

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

The quality indicators for 2021/22 can be seen below and have been reported in section 2 of this report:

Patient Safety Domain

- Gram Negative Bloodstream Infections – A 5% Reduction in Gram Negative Bloodstream Infections (GNBSI).
- Improvement in the communication process for DNACPR
- COVID-19 Recovery, waiting list management, appropriate clinical review oversight

Clinical Effectiveness Domain

- Embedding the Medical Examiner role across the Trust and Community Services.
- Ensure effective decisions about health care are based on the best available, current, valid reliable evidence.
- CBU Governance to be strengthened ensuring consistency across the organisation.

Patient Experience Domain

- Implementation of the End of Life Serious Illness Programme
- Development and implementation of the Trust Learning Disability and Mental Health Strategies.
- Nutrition- to ensure that patients have access to a choice of food and nutrition.

3.6 Parliamentary and Health Service Ombudsman

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

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

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

The table below details the progress of cases over the year within the Trust.

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
PHSO cases received	1	0	0	0	1	1	1	0	1	0	1	0
PHSO cases closed	0	0	1	2	0	0	0	1	0	0	1	0
Ongoing PHSO Cases at the end of 2021/22 = 5												

3.9 Friends and Family scores 2019/2020 and 2020/21 are as follows:

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

The 2020 Inpatient survey was undertaken by Quality Health, on behalf of the Trust and covers all aspects of patient's admission, care and treatment, operations and procedures and discharge from hospital from the inpatient specialties of General Surgery; Urology; Trauma and Orthopaedics, Cardiology, Acute Internal

Medicine, Stroke and Respiratory Medicine. The results of the Inpatient Survey (2020) were received by the Trust in September 2021 with results published by the CQC in October 2021.

The survey required a sample of 1250 consecutively discharged inpatients aged 16 and over, this sample is worked back from 30th November 2020. The final response sample was 1182 due to changes in respondent's circumstances such as not known at address or deceased. The target response rate is 60%; Trust response rate was 42%, a 2% increase in comparison to the 2019 response rate (40%).

The NHS Inpatient survey provides the Trust with intelligence around the overall patient experience, and it is vital that we review and act upon this information to address poor performance. The Picker Institute coordinates all the national results on behalf of the CQC, who publish reports which include benchmarks against performance. Seventy-six questions are asked and categorized into twelve domains as follows:

- **1.1.** Admission to hospital
- **1.2.** The hospital and ward
- **1.3.** Doctors
- **1.4.** Nurses
- **1.5.** Your care and treatment
- **1.6.** Operations and procedures
- **1.7.** Leaving hospital
- **1.8.** Overall
- **1.9.** About you

On review of the 2020 survey results evidence of improvement since the 2019 survey is detailed below:

The Hospital and Ward

- 27% of respondents rated hospital food as 'Very good', this is an increase of 11% in comparison with the 2019 results at 16% and 2018 at 23%.
- 66% of those surveyed stated they always got enough help from staff to eat their meals, this is an increase of 9% in comparison with the 2019 survey at 57%.

Doctors

- 78% of respondents felt that when asking doctors questions, they got answers they could understand, this is a 10% increase in comparison to the 2019 survey at 68% and rates better than the Quality Health average.
- 87% of respondents 'always' had confidence and trust in the doctors treating them, this is a 10% increase in comparison to the 2019 survey at 77%

Nurses

- 81% of respondents felt that when asking nurses questions, they 'always' got answers they could understand, this is an increase of 12% in comparison to 2019 at 69% and is 2% above Quality Health average.
- 86% of those surveyed stated they 'always' had confidence in the nurses treating them, a 6% increase in comparison to 2019 at 80%.

Overall

- Of those surveyed 87% stated they were 'always' treated with respect and dignity whilst in hospital, compared with 2019 results at 79% this is an 8% increase and is just short of the top 20% of Trusts who participated with Quality Health.

- Overall, 44% of surveyed respondents rated their experience a '10 – I had a very good experience', this is an increase of 20% in comparison to 2019 at 24%.

Some scores for Warrington and Halton Teaching Hospitals NHS Foundation Trust are in the intermediate 60% range of Trusts surveyed by Quality Health. Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, central to the Trust ethos is the view that patients deserve high-quality healthcare, and patients' views and experiences are integral to successful improvement efforts. As such it employs Quality Health to undertake a robust and comprehensive survey of patients experience on an annual basis.

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

The National Inpatient Survey key themes had been reviewed in full and have been scrutinised. There has been significant work undertaken by the CBUs, with the implementation of the five work streams of the Patient Experience Strategy, led by Lead Nurses and Allied Health Professionals, who provide monthly updates to the Patient Experience Sub Committee. Warrington and Halton Teaching Hospitals NHS Foundation Trust are focusing on the following themes as a result of the feedback in the survey.

- Admission to hospital – examining reasons why some patients have long waits to be admitted to a ward, this will feature as part of focus on flow workstreams ensuring that findings from the survey are linked into operational delivery.
- Noise at night – continued focus into why some patients experience high levels of noise from other patients at night. This will involve collaborative and multi-disciplinary quality improvement projects.
- Food and Hydration – Continued focus to review food quality, temperature, timing, and support for patients incorporating findings from the survey with the Independent Review of NHS Hospital Food report. recommendations.

3.9 Friends and Family

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

When patients visit our Emergency Department (ED)for treatment, or are admitted to hospital, they are asked to complete a short survey when they are discharged. This details how likely they are to recommend the ward/department or ED to friends and family if they needed similar care or treatment. The patient's response is anonymous, and they can post the paper survey into the confidential box on their way out of the ward or A&E. The boxes are emptied regularly to process the information and provide reports to the Ward Manager and Matron. Friends and Family Test (FFT) surveys now has increased functionality available for patients attending WHH 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.

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

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

Friends and Family scores 2019/2020 and 2020/21 are as follows:

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

	Inpatient 2019/20	Inpatient 2020/21	Inpatient 2021 / 22	A&E 2019/20	A&E 2020/21	A&E 2021/22
Apr	95%	FFT Paused	98%	82%	94%	79%
May	96%	FFT Paused	98%	84%	91%	78%
Jun	96%	FFT Paused	98%	82%	89%	77%
Jul	94%	FFT Paused	96%	82%	89%	73%
Aug	95%	FFT Paused	96%	83%	84%	70%
Sept	96%	FFT Paused	97%	78%	87%	72%
Oct	95%	FFT Paused	96%	78%	81%	68%
Nov	96%	FFT Paused	98%	77%	86%	73%
Dec	96%	FFT Paused	97%	78%	93%	75%
Jan	95%	98%	98%	81%	93%	75%
Feb	95%	94%	97%	81%	86%	71%
Mar	FFT Paused	97%		*	79%	

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

3.10 Duty of Candour

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

For each new Serious Incident (SI) investigation, a patient or family liaison officer continues to be appointed to provide support and advice. A 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.

3.11 Staff Survey Indicators

The staff survey for 2021 has evolved to reflect the updated NHS People Plan which was updated in 2021. [1] Table **one** highlights the promises and themes that are reflected in the 2021 staff survey results.

Table One: People Promises and Themes in the 2021 Staff Survey

People Promise (PP) / Theme (T)	Subscore / Theme
We are compassionate and inclusive (PP)	• Compassionate culture • Compassionate leadership • Diversity and equality • Inclusion

People Promise (PP) / Theme (T)	Subscore / Theme
We are recognised and rewarded (PP)	N/A
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 2021: www.england.nhs.uk/ournhspeople/	

The most updated results from the 2021 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 8.49 for this theme overall which is higher than the comparison with the Acute Trust average of Trust's utilising Quality Health as their survey provider of 8.05.

For question 14- Does your organisation act fairly with regards to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age the Trust scored 63% compared to the Acute Trust average of organisation's utilising Quality Health as their survey provider of 55%. The Trust are above the national Acute Trust average of Quality Health Trust's, however, recognises the importance of ensuring equity in relation to progression and promotion and has worked in collaboration with the Trust's Staff Networks to develop 1:1 career coaching sessions and training opportunities to support individuals through their career progression. In addition, a reciprocal mentoring scheme has been implemented and supported across the organisation in partnership with Staff Network members. The organisation also has specific action plans in place aligned to the Workforce Race Equality Standard, the Workforce Disability Equality Standard and the Model Employer action plan to continue to improve this the experience of our staff in relation to acting fairly in terms of career progression or promotion irrespective of protected characteristic.

We are safe and healthy

In relation to harassment, bullying or abuse question 13b asks "how many times have you personally experienced harassment, bullying or abuse at work from managers? The Trust scored 12% which is a slight increase on the 2020 score but lower than the Acute Trust average of organisations utilising Quality Health as their survey provider which is 13%. The Trust recognises the importance of an inclusive culture and an environment where individuals feel safe within the workplace. To support improving this metric, a targeted action plan has been developed in partnership with Staff Side colleagues and members of our Staff Networks to implement a kindness, civility and respect campaign aligned to the new organisational value of "kindness". In addition, the organisation has developed an implementation plan to working towards becoming an Anti-Racist organisation and has signed up to the Social Partnership Forum's "Call to Action" in relation to bullying and harassment within the NHS. In addition to campaigns and visible commitments, policy levers such as the Grievance policy has been

refreshed to focus on enabling positive work environments which will be further enhanced with the implementation of the Line Manager development framework.

For question 13c – “In the past 12 months how many times have you personally experienced bullying, harassment or abuse at work from other colleagues? The Trust scored 19% which is an increase on the 2020 score but remains lower than the Acute Trust average with organisations utilising Quality Health as their survey provider of 21%.

12 Quality Academy

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

Objectives

Our Key priorities for the Quality Academy are:

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

Engagement

Key to ensuring that we are listening to our stakeholders and addressing what matters to them. The Quality Academy actively seeks, listens and acts on feedback received from our patients, the public, our staff and groups such as Governors, HealthWatch and Health Scrutiny Committees.

The Quality Academy work being undertaken with the Patient Experience and patient involvement agenda to ensure that the patient voice is integral to Quality Improvement. The Quality Academy also works with Workforce & Organisational Development, to ensure that staff engage in the agenda and are empowered and supported to make improvements in their work.

Quality Academy Showcase

Each year we hold our annual Quality Academy Showcase. The showcase presents the latest innovation, best practice, improvement and research. The teams in the academy work together with our internal and external partners to deliver the latest knowledge in innovation and improvement in healthcare. An event has taken place this year and a further event is scheduled on 11th July 2022. The event is a unique opportunity to discover the art of the possible, bringing teams together to deliver better outcomes for our patients as well as raising the profile of the Quality Academy and the services available.

Quality Improvement

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

Quality Improvement Projects overview

Falls Collaborative

The Falls Collaborative relaunched in April 2021 following a break in QI projects during the Covid-19 Pandemic. The baseline for the number of falls was 64.75 falls. The collaborative aim was to reduce this by 20% to 51.8 falls per month by March 2022. The current average is 50.1 falls per month, demonstrating that we are on target to achieve this aim.

This year we developed and launched a Trustwide Falls Change Package. This collated all the great work that Collaborative wards have completed and compiled them into 6 evidence based changes that wards are asked to implement in order to reduce the number of falls.

Pressure Ulcer Collaborative

The Pressure Ulcer Collaborative also restarted in April 2021 following the resumption of collaboratives after the Covid 19 pandemic. Working closely with wards, we also launched a Pressure Ulcer Change Package which was launched Trustwide in October 2021. Since this launch, the QI team has been working with all wards across the Trust to implement these changes.

Gram Negative Bloodstream Infections (GNBSI) Collaborative

Reduction of GNBSI has been identified as a 2021/22 Trust quality priority. Based on the learning from ward tests, a change package outlining evidence-based interventions will be developed in the next financial year for all wards to implement. Our aim to reduce hospital acquired GNBSI by 5% by the 31st March 2022 in line with national targets has been met.

Eight innovation wards are currently being supported to develop tests of change in five key areas identified for improvement:

- Hydration
- Oral care
- Continence care
- Catheter management
- Hand hygiene

We support wards with fortnightly joint walkarounds by the IPC and QI team, to prevent further delays in sharing best practice across the Trust. We are also developing a GNBSI prevention care bundle based on a combination of the best available evidence, alongside learnings from the innovation wards to date.

In addition, the UTI pathway has recently been revised and will soon be launched. We intend to provide targeted QI support to implement the new pathway on wards identified as having a high number of infections likely of urinary source.

Quality Improvement Projects (QIPs)

The Quality Improvement Register was established in 2019 to capture improvement projects that are being undertaken across the Trust and enable the QI Team to allocate the appropriate level of support to individuals/teams undertaking improvement work. 45 Quality Improvement Projects were registered in 2021/22.

Quality Improvement Capability Building Programme

A new WHH Quality Improvement Education Framework has been developed to ensure the Trust has a structured and strategic approach to building QI knowledge and capability within our workforce. The QI team is also in the process of increasing buy in through a new QI champion network to be set up across the Trust. A key component of this will be to recruit medics to improve engagement.

Since April 2021 the QI team has delivered new training to 203 staff members. Table 2 shows a breakdown of the courses and number of staff who have successfully completed them. A monthly schedule of training dates for the next calendar year has been advertised.

QI Training Staff Numbers

Course	Number of staff
QI Foundation	132
QI Practitioner (3-day programme)	6
Preceptorship – Introduction to QI	65
Total	203

3.13 Local Quality Initiatives

Improving quality provides an opportunity to deliver better outcomes. There are many examples at Warrington and Halton Teaching Hospitals NHS Foundation Trust that show that even relatively small-scale quality improvement initiatives can lead to significant benefits for patients and staff. The section below details some of the positive work that we have achieved in 2021/2022.

Support for International Nurses

The Trust developed an Objective Structured Clinical Examination and support booklet to help international nurses to fully prepare for their clinical examination assessments. The learning and resources prepared were shared with the Mid Cheshire Collaboration as best practice.

Nursing Times Awards

Ward A7 and the Acute Care Team collaboration were shortlisted for the Nursing Times Awards 2020 Team of the Year.

HSJ Awards

The Trust were finalists for the HSJ Awards for the Urgent & Trauma Care initiative for introduction of the Thoracic Injury Pathway.

Stroke garden

The Trust opened a new Stroke therapy garden to support patients on the Stroke Unit. The garden is used by patients and families and was funded through WHH Charity fundraising, donations and supported by Sellafield Ltd and Warrington Lions Club.

PEWS testing

The Trust was successful in becoming a pilot site for the introduction of a National Paediatric Early Warning Score - SPOT. The PEWS inpatient trial was successfully piloted between April and September 2021

Employer Recognition Scheme - Silver award 2021 - Proudly serving those who serve

The Trust is one of thirty-six organisations from across the North West of England that have been awarded Silver under the Ministry of Defence Employer Recognition Scheme for their support to Defence and the wider Armed Forces community. The Employer Recognition Scheme was launched to reward employers who support Defence People objectives and encourage others to do the same. This includes employing serving and former members of the Armed Forces community and demonstrating flexibility towards training and mobilisation commitments for Reservists and Cadet Force Adult Volunteers.

Post Anaesthesia Care Unit (PACU)

Prior to the Covid-19 pandemic, patients requiring elective surgery who were deemed to have a greater perioperative risk were booked for a postoperative critical care bed on the Warrington site, which is the main Trust site with ITU and ED. This bed was not guaranteed depending on critical care occupancy and dependency, and often led to late cancellation of patients. During the Covid-19 pandemic and the increased pressure on critical care beds, it was imperative that an alternative to critical care was available to provide a safe level of care for this cohort of patients and facilitate the Trust's elective recovery plan. The Trust was keen to utilise the Halton Elective site as a 'green pathway' for elective surgery with the addition of a PACU to increase the number of patients who could be safely managed there. The Associate Chief Nurse for Planned Care developed a Standard Operating Procedure (SOP) for PACU with input from key members of the multidisciplinary team.

The PACU was opened in 2021 and has enabled effective care to be provided for these patients supporting the Trust's elective recovery. The Trust also won the Cheshire and Merseyside Continuous Improvement Award in 2022 for the PACU.

Sharing best practice in Infection Prevention and Control

The triage tool for Covid used in our Emergency Department was recognised by NHSE/I as best practice and share across the North West Region.

Bereavement Garden

The Trust opened a remembrance garden, created as part of its COVID-19 legacy. The area is a quiet, peaceful and reflective space for staff, patients, bereaved relatives and members of the community to visit and remember.

The garden features an array of flowers, trellises and seating areas with wooden benches and was designed by a local landscaper on a previously unused and rather unloved patch of grass between the new Habab Training Centre and the old K23. At the centre of the garden is a beautiful stone birdbath that was donated by the family of the late Tony Nicholson, who sadly passed away last year in the ICU with COVID-19. The Trust held a short ceremony to formally open the garden and some of Tony's family members attended the event, including his sister and brother-in-law Sue and Matthew Walker and his nephew.

As well as being a beautiful place for staff and bereaved families to visit and reflect, the Trust also recognises the value that this, in partnership with our Bereavement Service, adds to those who lose loved ones at the Trust's hospitals.

Ambulance Handover Times

The Trust's Emergency Department has featured in Hospital Handover Improvement as a case study outlining the quality improvement piece of work undertaken to improve hospital handovers from ambulances to the Trust's ED Team. The improvement work has been shared across the North West region with other Trusts as best practice, having consistently demonstrated an improvement in ambulance handover times.

Operating Department Practitioner (ODP) apprenticeships

The Theatres Team have been instrumental in bringing about an innovative new degree apprenticeship. The OPD Degree Apprenticeship concept came from a postgraduate certificate-enabled project at the Trust focussing on exploring the impact of professional apprenticeships in the peri-operative environment.

Using this experience, the Trust collaborated with other Trusts to enable the University of Bolton to devise and deliver the course. Each student is able to study alongside their practical work and is supported by an Educator within the department. The first cohort of the new BSc (Hons) Operating Department Practice (Degree Apprenticeship) at the University of Bolton have just completed their studies and are awaiting their pin numbers from the Healthcare Professional Council before becoming fully qualified ODPs.

Echo Training Programme

The Trust currently performs 6,000 echocardiograms annually across both sites, with a staff of six qualified Echocardiographers and one in training, with five Imaging Consultants who perform and support all modalities of echocardiography performed at the trust.

There is currently a national shortage of suitably trained and Accredited Echocardiographers across the NHS workforce. The National School of Healthcare Science (NSHCS), in collaboration with the British Society of Echocardiography (BSE) has developed a pilot pathway that will respond rapidly to the urgent workforce needs for Accredited Echocardiographers. The pathway is an 18-month, full-time integrated training scheme to deliver academic and workplace training leading to both a post-graduate certificate in Echocardiography and Level 2 BSE Accreditation in Transthoracic Echo. There are currently only two universities offering the academic portion of the ETP programme; Manchester Metropolitan and University of Newcastle, making the Trust's hospitals ideally situated for students on the programme.

The Clinical Leads for echocardiography recognised the value of the programme and applied to be a host training centre for the Echocardiography Training Programme (ETP). The application was successful, and the trainee application process will begin in Spring 2022, leading to one trainee arriving at the Trust in September 2022to train over 18 months to become accredited and potentially recruited by the Trust. The ETP is in its infancy and WHH are forward thinking in getting involved so early in the programme.

Newborn Life Support Course

The Resuscitation Council UK (RCUK) Newborn Life Support (NLS) course focuses specifically on the resuscitation of the newborn infant, teaching the essential practical skills and theoretical knowledge needed to best aid the newborn infant in an emergency. The course is intended for any healthcare professional involved in the delivery and care of the newborn infant. This includes nursing staff, midwives, paramedics, resuscitation officers and both junior and senior medical staff.

The Trust is one of only two centres in the Northwest that offers the NLS course. RCUK has only accepted 10 centres nationally to deliver the course in 2022. As WHH is only one of the handful of trusts able to offer a national qualification on resuscitation of the newborn infant, the trust is now considered to be a centre of excellence in resuscitation training and education on the national agenda.

Joint Advisory Group for Endoscopy (JAG re-accreditation)

JAG accreditation is awarded to high-quality gastrointestinal endoscopy services In February 2022 the Trust's Endoscopy Unit was inspection by the Joint Advisory Group for Endoscopy. The Trust received very positive feedback and was re-accredited.

HSJ Partnership Awards

The Trust was highly commended at the HSJ Partnership Awards 2022 for the Best Elective Care Recovery Initiative.

3.15 Performance against key national priorities

National Targets and Minimum Standards	Indicator	Target 2021/22	2021/22	2020/21
Infection Control	Number of clostridium difficile cases due to lapses in care	<= 27	6	0
	Number of MRSA blood stream infection cases	0	1	1
Cancer: 31 day wait from diagnosis to treatment	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	97.74%	95.60%
Cancer: 31 day wait for second or subsequent treatment	Anti cancer drugs	98%	**100%**	100.00%
	Surgery	94%	**100%**	98.53%
Cancer: 62 day wait for first treatment	From urgent GP referral (Reallocation position)	85%	70.36%	72.55%
	From the consultant screening service	90%	93.12%	91.94%
Cancer: 2 week wait from referral to date first seen	Urgent GP referral suspected cancer referrals	93%	86.64%	88.56%
	Symptomatic breast patients (cancer not initially suspected)	93%	76.56%	79.80%
Referral to Treatment within 18 weeks	Admitted patients with a clock stop		57.16%	58.35%
	Non-admitted patients with a clock stop		83.01%	81.47%
	Patients on an Incomplete pathway End of March position	92%	72.28%	70.14%
Access to A&E	Patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	72.76%	85.86%
Access for patients with a learning disability	The Trust provides self-certification that it meets the requirements to provide access to healthcare for patients with a learning disability	N/A	YES	YES
Cancelled operations on the day for a non-clinical reason **	Number of Cancellations not offered a date for readmission within 28 days	0	13	54
	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	<= 2%	0.47%	0.42%

	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not readmitted within 28 days		17.76%	54.21%

** These figures are subject to change

3.16 Quality Report request for External Assurance

This not required for 2021/22

Annex 1: Quality Report Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees and other stakeholders 2021/22 are presented within this document unedited by the Trust and are produced verbatim.

Re: Quality Accounts 2021 - 2022

I am writing on behalf of partners to express our thanks for the submission of the Warrington and Halton NHS Foundation Teaching Trust Quality Report and presentation for 2021 – 2022 and this letter provides the response from NHS Halton and NHS Warrington Clinical Commissioning Groups (CCGs).

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

The impact of the pandemic as you have stated has been challenging and led to several business-as-usual activities, being suspended or in later months being slowly re-introduced so that resources could focus on providing an effective and supportive response to the health system, in line with national directions. We recognise this may have slowed progress in achieving some of the quality priority objectives set for 2021 / 2022 and understand your continuance of some quality priorities as well as additions into 2022-2023.

We note the priorities, key achievements and progress made in 2020 – 2021:

1. The CCGs welcomed the presentation and report.
2. The CCGs would like to commend the Trust for the Strategy for Learning Disability and Mental Health which was developed with a range of key stakeholders enabling excellent practice.
3. The introduction of small changes such as the dementia snack boxes, and pizza take out for children has a major impact on their experience.
4. The CCG acknowledge the challenges the Trust has faced in relation to DNACPR and note the mechanisms put in place to address this including training, electronic documentation and the follow up audits which show good improvement
5. Good reference to GIRFT and NICE – collaborative research working with LUFHT
6. Positive indication in work around incidents in terms of increased reporting whilst reducing harm.

NHS Halton and NHS Warrington CCGs have noted and accept Warrington and Halton NHS Foundation Trust Improvement Priorities for 2022 - 2023:

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

1. 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.
2. 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 and to initiate patient forums during 2022.

The CCGs recognise the challenges for providers in the coming year as we all continue to recover from the Covid pandemic, and we look forward to continuing working with Warrington and Halton NHS Foundation Teaching Trust during 2022 – 2023 as you continue to deliver improvement in service quality, safety and patient experience, as well as 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 NHS Warrington CCGs would like to take this opportunity to say thank you to Warrington and Halton NHS Foundation Teaching Trust and 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 for your on-going commitment locally to system partnership working.

Statement from Warrington and Halton Clinical Commissioning Groups

As above no additional comments received- combined response.

Statement from the Halton Health Policy Performance Board

As above no additional comments received- combined response.

Statement from the Trust's Council of Governors

On the 05 April 2022, Governor N Holding - on behalf of the Council of Governors

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2021/2022.

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 Quality Committee and the Trust Chair. At these meetings the Governors receive the latest performance information and have the chance to analyse it and raise questions. All Governors receive the Trust's dashboard monthly and can table queries to the 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. All these activities have continued in a virtual format thereout the last year.

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

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

For the coming year, the Governors agree with the priorities established. **The Patient Safety Priorities** relating to: Improving Sepsis screening and timely management. Waiting list management in line with national guidance and clinical priorities and Evidence a culture of Quality, Safety and learning aligned to National Patient Safety Framework. **The Patient Experience Priorities,** Implementation of the Trust Learning Disability and Mental Health Strategies. Nutrition and Hydration – To ensure that Patients have access to a choice of food and nutrition. Health inequalities addressed through Patient centred communications Finally, Governors see the **Clinical Effectiveness Priorities** regarding, Evidence a culture of Quality, Safety and Leaning across clinical services, "Get it right first time" clinical productivity programme to be implemented across all specialities to deliver enhanced quality and productivity. and to Strengthen the Discharge Process to improve the quality of discharge to home and community providers. as key areas for delivery of a better all-round patient path through the hospital.

The Governors are happy that the 2021/22 Quality Report provides data that is more meaningful, understandable, and clearer to all, the report shows indicating trends, and comparisons with the previous year statistics. For the coming year, the Governors will review the Quality Report quarterly.

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

Governors believe the Quality Report to be accurate. The graphs and accompanying explanations help the public and members to understand clearly the progress made in many areas of patient safety and patient care.

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

Statement from Warrington Healthwatch

Noted within the CCG letter following presentation with all key Stakeholders

Statement from the Halton Healthwatch

Noted within the CCG letter following presentation with all key Stakeholders

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

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2021 to date of signing this statement
    - Papers relating to Quality reported to the Board over the period April 2021 to date of signing this statement
    - Feedback from the Commissioners, Warrington Clinical Commissioning Group and Halton Clinical Commissioning Group dated **17/6/2022**
    - Feedback from Council of Governors dated 05 April 2022
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated 17/6/2022 and Healthwatch Warrington dated **17/6/2022**
    - Feedback from Overview and Scrutiny Committee dated **17/6/2022**
    - Feedback from Halton Borough Council dated **17/6/2022**
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated **4/5/2022**
    - The 2021 national adult inpatient survey under embargo until June
    - The 2021 national staff survey published – under embargo until June
    - CQC inspection report dated 24 July 2019

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Date 25th May 2022 **Steve McGuirk Chairman**

Date 25th May 2022 Simon Constable **Chief Executive**

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

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

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

Appendix – Glossary 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?”
Governors	Governors form an integral part of the governance structure that exists in all NHS foundation trusts; they are the direct representatives of local community interests in foundation trusts
Healthwatch	Healthwatch is a body that enables the collective views of the people who use NHS and social care services to influence policy.
Healthcare evaluation data (HED)	Clinical benchmarking system to support clinical experts in more effective management of clinical performance.
Hospital episode statistics (HES)	Is a database containing information about patients treated at NHS providers in England.
Hospital Standardised Mortality Review	Is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

Abbreviations	Definitions
(HSMR)	
Information governance	Ensures necessary safeguards for, and appropriate use of, patient and personal information.
Mandatory training	The Organisation has an obligation to meet its statutory and mandatory requirements to comply with requirements of external bodies e.g., Health & Safety Executive (HSE), training is provided to ensure that staff are competent in statutory and mandatory
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
MSSA	Methicillin-sensitive *Staphylococcus aureus* (MSSA) is a bacteraemia caused by Staphylococcus aureus which is a serious infection associated with high morbidity and mortality and often results in metastatic infections such as infective endocarditis, which have a negative impact on patient outcomes
National confidential enquiries (NCEPOD)	The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.
NHS Improvement	NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
National inpatient survey	Collects feedback on the experiences patients who were admitted to an NHS hospital in 2019.
National institute for health and clinical excellence (NICE)	Is responsible for developing a series of national clinical guidelines to secure consistent, high quality, evidence based care for patients using the National Health Service.
National institute of health research (NIHR)	Organisation supporting the NHS.
National patient safety agency (NPSA)	Lead and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
National reporting and learning system (NRLS)	Is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.
Never Events	Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS outcomes framework	Reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. To act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.
Open and Honest	North of England Trusts produces and publishes monthly reports on key areas of healthcare quality.
Palliative care	Focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.
Patient Reported Outcome Measures (PROMs)	Provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.
Payment by results (PBR)	Provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix.
Safety thermometer	Is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care?

Abbreviations	Definitions
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