NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Quality Account

2023/24

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

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Introduction

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

We welcome the opportunity to outline how we have performed over the course of 2023-24, taking into account the views of service users, carers, staff and the public. This Quality Account outlines the good work that had been undertaken, the progress made in improving the quality of our services and identifies areas for improvement.

As Wirral's largest employer, Wirral University Teaching Hospital NHS Foundation Trust is the thriving heart of the local community. Comprising Wirral's only Emergency Department, it is one of the biggest and busiest acute NHS trusts in the North West.

With state-of-the-art facilities based within a fast-paced and ever-developing environment, this forward-thinking Trust is on an exciting journey of transformation.

The Trust has been recognised by numerous national awards over the past 12 months in areas including dermatology, dementia, patient experience, patient safety, scientific innovation and staff engagement.

Our workforce of over 6,000 staff serves a population of approximately 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West.

The Trust operates from two main sites:

• Arrowe Park Hospital, Upton – delivering a full range of emergency (adults and children) and acute services for adults in the main hospital building. The Wirral Women's and Children's Hospital provides maternity, neonatal, gynaecology, children's inpatient, day case and outpatient units.
• Clatterbridge Hospital, Bebington – undertaking planned surgical services, dermatology services, breast care and specialist stroke and neuro rehabilitation services.
Outpatient services are provided from community locations including:
• St Catherine's Health Centre, Birkenhead – providing x-ray, community paediatric services, paediatric audiology and a range of outpatient clinics.
• Victoria Central Health Centre, Wallasey – providing x-ray, some outpatient services and antenatal clinic.
Seacombe birthing centre, Seacombe - providing midwifery led birthing options
• GP practices, schools and children's centres.

Our full range of services include:

• accident & emergency services for adults and children
• a diverse range of acute and non-acute specialties
• outpatient services
• day surgery services
• maternity including a midwifery led unit
• diagnostic and clinical support services
• specialist services including:
  - renal medicine
  - dermatology
  - orthopaedics (hip & knee revisions)
  - ophthalmology (retinal)
  - urology (cancer centre)
  - stroke (hyper-acute unit)
  - gynaecology (advanced laparoscopic endometriosis centre)
  - neonatal level 3 unit and
  - Ronald McDonald House: charity home providing accommodation for parents of sick children and premature babies.

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

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

Statement of the Quality Account

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

It is with great pleasure we publish our annual Quality Account and, as always, the quality of our patient care remains the top priority for the Trust.

Following a further year of sustained pressures through recovery of the Trust elective care programme, continued industrial action and significant progress with developments including the Trust Urgent and Emergency Care Upgrade Programme, Cheshire and Merseyside Surgical Hub and the Clatterbridge Diagnostic Centre, quality and patient safety have remained at the heart of all decisions.

The Quality Account recognises progress against all of the Trust quality priorities in 2023/24 and full achievement of two, Empowering Patients and Safe Transfers, with partial achievement of the third, Management of the Deteriorating Patient, that continues into 2024/25.

The quality priorities for 2024/25 have been co-produced with a range of internal and external stakeholders through workshops and surveys. Alongside the continuation of work around Management of Deteriorating Patients, further work around Documentation at Transfer and Discharge and work to further reduced Clostridium Difficile Infection rates have been identified as priorities for quality improvement. These areas recognise some of the most significant challenges within the Trust and demonstrate a shared understanding of focus and direction.

We are proud of our continued strive to enhance clinical effectiveness within the Trust and the account clearly demonstrates our commitment to clinical audit and research to support further progress toward clinical excellence. It is widely accepted the healthcare settings with high levels of active research often deliver better patient outcomes and therefore the Trust continues to promote a research active environment.

The greatest asset of any healthcare provider is our workforce. This quality account also explores our workforce support. It is positive to see the continued strengthening of our freedom to speak up offer and that most colleagues who utilise this service do so without anonymity demonstrating our progress towards just and learning culture.

The NHS Staff Survey is a key tool to support the Trust to get it right for our workforce. The results of the staff survey have been mapped to the People Strategy and are being used to inform priorities for next year.

The quality account notes the implementation of the Patient Safety Incident Response Framework (PSIRF) driving a significant shift in the way patient safety events are investigated across the NHS and prioritising measurable sustainable quality improvement. This drive has been challenging, however, was both delivered in line with national timescales and is already having a positive impact on learning and improvement.

Alongside the implementation of PSIRF the Trust has developed a thriving cohort of Patient Safety Partners who, through volunteer roles, are able to provide an independent perspective on the Trust patient safety activity and provide a diverse perspective on potential quality and safety improvements.

During the year the Trust identified two Never Events, in line with rates from the previous year; however, the Trust continues to strive to eliminate Never Events. Both Never Events have been investigated and these Quality Governance processes have enabled improvements.

The forthcoming year is an exciting period for the Trust continuing to deliver the Quality and Patient Safety Enabling Strategy to support a just and learning organisation, utilising the insight through data, expert clinical knowledge and,, most importantly the engagement with our patients and public to deliver sustainable and measurable improvements in quality.

Janelle Holmes

Chief Executive Officer

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

Our Values

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

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

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

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

WUTH Strategic Framework

In 2020-21, Our Strategy 2021-26 was launched following engagement with over 2500 members of staff, patients and visitors. This strategy sets out our strategic direction during this five-year period and introduced our vision, values and strategic objectives.

Our vision is clear and ambitious, shaping our future and responding to the challenges we face, as displayed below with our four Trust values which are expected of us all

together we will

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

Underpinning our vision and values are the six strategic objectives, each with a set of priorities which set out our ambitions and detail the ways in which we will improve the delivery and quality of care, support our workforce and embed a culture of improvement across the organisation. Our strategic objectives are incorporated into all aspects of planning across the Trust to ensure that all efforts for improvement are aligned to our strategic direction. These objectives are:

Enabling strategies

Following the successful launch of our 2021-2026 Strategy, the delivery of this is observed through our eight enabling strategies. These strategies provide more detailed objectives and priorities across the different areas of the Trust, including specific objectives and priorities for each of our 32 clinical services through our Clinical Service Strategy which is now reaching the midpoint of delivery. In recognition of this, each of the 32 clinical services are reviewing their progress in the delivery of their clinical strategy in order to provide updated plans on the delivery of remaining priorities. The development of our enabling strategies culminated in 2022-23 with the launch of the Financial Strategy, and the suite of eight enabling strategies is complete as displayed below:

Annual Strategic Priorities

Each financial year, the delivery of each strategy is planned and measured through the Annual Strategic Priority cycle. At the beginning of each financial year, the five clinical divisions and the Executive Team set out their priorities for the year ahead against the six strategic objectives, and

present these at the Bi-annual Strategic Priority Event. These are then updated and shared at a second event half-way through the financial year. In 2023-24, all enabling strategy leads were also invited to take part in this process, delivering a market-place in the Education Centre to provide updates on the delivery of each strategy. This will be carried through to the 2024-25 Bi-annual Events and will be opened up to the wider workforce as an opportunity to network and engage in the delivery of our priorities.

2. Priorities for Improvement

2.1 Update on Priorities for 2023-24

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

1. To empower patients by increasing the opportunities to expand their role as partners in their own healthcare.
* Continued roll out of the Patient Initiated Follow Up programme, ensuring patient led decision making about the need for follow up appointments

2. To improve planning and preparation for safe transfer of care from hospital when a patient's period of inpatient admission is no longer required.

3.To build upon recent progress and further improvement management of the Deteriorating Patient.

2.1.1 Empower Patients

Fully Achieved

During 2023/24 this has continued as a priority area for the Trust and patient engagement has been a strength with huge value added by the generous voluntary support from our local population. This has allowed co-production of various initiatives including; a discharge checklist, needle phobia film, voice of the child consultation, health and carer passport signage, ward folders and mental health privacy notice for ED.

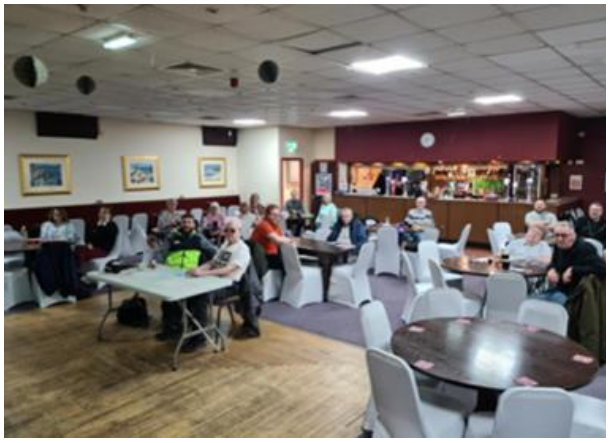
The world patient safety day celebrations in September 2023 focused on patients as partners in their care and celebrated a range of opportunities to support this.

Recruitment of Patient Safety Partners (PSP) has progressed with our first PSP actively supporting patient safety programme across the Trust and further PSPs progressing through recruitment.

A Self Medication working group has been established enabling pilot wards to champion self-medication process and enabling patients to manage their own medications where appropriate. This is a key driver in maintaining independence, joint care planning and shared ownership of care.

Partnership working with Wirral Mencap, Wirral Multicultural Organisation, WIRED and Merseyside Society for Deaf People has identified new opportunities for reducing inequality in accessing Trust services. This has led to task and finish groups including:

- Hidden Disabilities,
- Deaf Awareness,
- Gender Inclusive,
- Mental Health Experience
- Young Carers.



2.1.2 Safe Transfer

Fully Achieved

During 2023/24 the Trust has revised transfer of care. The Trust led Transfer of Care Hub has seen a marked reduction in the number of patients who no longer meet the criteria to reside. Our approach has been noted as an example of good practice by NHS England to support the safe and effective transfer of patients we have and implemented a new discharge policy. A co-produced discharge checklist has been developed and disseminated across all areas to support clear discharge planning and promote joint planning with staff and patients/carers. The Trust continue to monitor the uptake of joint planning using the discharge checklist and address areas for improvement.

Patient Ward Folders have also been co-produced to improve communication with patients about the discharge process, discharge preparation and post discharge support.

The National CQC Inpatient Survey banded the Trust 'Better' for the question about patient understanding of post discharge information.

The National CQC Maternity Survey banded the Trust 'Better' for the question about contact information if advice were to be needed post discharge regarding mental health.

The Trust was banded in top 5 regional Trusts for care at home after birth in the CQC Maternity Survey.

2.1.3 Improve Management of Deteriorating Patient

Partially Achieved

The Trust has an active deteriorating patient group to support understanding of the challenges and leading quality improvement work in this area. There has been a significant reduction in incidents identifying delays in identification and management of deteriorating patients.

The recording of NEWS2 is currently undertaken in our Electronic Patient Record (EPR) system. To improve ease of recording, timeliness of entry and accuracy, we have implemented the Vitalslink system whereby upload is taken directly from the Welch-Allyn recording device. The Vitalslink Project was paused following a strategic decision to complete Identify Management (Single Sign On) as a prerequisite due to the need to replicate QR codes following account matching where main accounts are linked to other system accounts within the Trust.

A pilot has taken place on ward 14 and ward 33 including the MET team. This has been deemed a success and the project now has approval from Patient Safety Quality Board (PSQB) to rollout Trust Wide.

The reporting tool on the Business Intelligence (BI) portal is active and well used. A group has been formed to look at all updates required to all early warning scores (adult, paediatric and maternity) so we can ensure all scoring systems are up to date and the language is relevant.

A review of Sepsis management has identified good compliance with 6 sepsis composite measures through the Advancing Quality Programme, leading to an overall top compliance across 15 North West Trusts.

2.1.4 Quality Priorities 2024/25

The development of the 2024/25 quality priorities has involved a robust process to review learning identified during 2023/24 and reported through the Trust Lessons Learned Forum. Learning has then been discussed with a wide range of internal and external stakeholders across the Wirral Place and a short list of seven potential quality priority areas were voted on by over 120 Trust staff members. This collaborative approach is intended to support use of a wide range of insight and develop Trust Wide ownership for quality improvement.

The final results have been discussed with the Trust Executive Team to conclude the following priorities for 2024/25:

Quality Priority	Success Measure
Reduction in rates of Clostridium Difficile Infection	Reduced rates of Clostridium Difficile Infection across the Trust in line with the local targets of below 9 cases per month. Full implemented the National Infection Prevention and Control Manual.
Identification of the Deteriorating Patient	Improved compliance with Deteriorating Patient Policy / NEWS2 compliance above 90% compliance. Reduce the proportion of MET calls in hours by increasing oversight by parent clinical team.
Supporting effective communication and accurate documentation during transfer of care	Transition to an Electronic SBAR communication handover as part of the EPR. Achieve compliance with completion of SBAR handover documentation on transfer. Improved Communication with external partners; GPs, Community Health Care Providers, Community Social Care Providers. Agree and monitor core standards of documentation on discharge or following appointments.

2.2.1 General Statement of Assurance

During 2023/24 Wirral University Teaching Hospital NHS Foundation Trust provided and subcontracted 85 relevant health services.

Wirral University Teaching Hospital NHS Foundation trust has reviewed all data available to them on the quality of care in all 85 of these relevant health services. The income generated by the relevant

health services reviewed in 2023/24 represents 100% of the total income generated from the provision of relevant Health Services by the Trust for 2023/24.

This year WUTH cared for:

	2022/23	2023/24
ED Attendances	93894	96611
UTC Attendances	35508	36574
Total	129402	133185
Births	3005	2897
Outpatient Attendance (all sites)	526307	516340
Inpatient Activity	59992	63023
Day Case Activity	46291	49784

WUTH employs 7365 substantive people. We engage with a large number of people through the bank system which raises this number to 7757. The employed people include 316 consulting doctors of which 5 are locum consultants.

2.2.2 National Audits

During 2023/24 the Trust participated in 94% (49/52) of National Clinical Audits applicable to Trust services. This is due to the wide range of Trust services with 52 out of a total of 71 national audits applicable to the Trust.

The Trust did not participate in 3 of the audits applicable to the Trust and the rationale behind this can be found at the end of the data table. The Trust participated in 100% of eligible National Confidential Enquires.

The National Clinical Audits and National Confidential Enquiries that Wirral University Teaching Hospital participated in during 2023/24 are as follows:

National Programme Name	Work Stream/ Topic Name	Should we Participate?	Case Ascertainment
Adult Respiratory Support Audit	N/A	Yes	100%
BAUS Nephrostomy Audit	N/A	Yes	100%
Breast and Cosmetic Implant Registry	N/A	Yes	100%

National Programme Name	Work Stream/ Topic Name	Should we Participate?	Case Ascertainment
Case Mix Programme (CMP)	N/A	Yes	100%
Child Health and Clinical Outcome Programme	N/A	Yes	100%
Elective Surgery, National PROMs Programme	N/A	Yes	100%
Emergency Medicine QIPs	Care of Older People	Yes	100%
Emergency Medicine QIPs	Mental Health (Self-Harm)	Yes	100%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	N/A	Yes	100%
Falls and Fragility Fracture Audit (FFFAP)	National Audit of Inpatient Falls	Yes	100%
Falls and Fragility Fracture Audit (FFFAP)	National Hip Fracture Database	Yes	100%
LeDeR – Learning from lives and deaths of people with a learning disability and autistic people	N/A	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - MBRRACEUK	N/A	Yes	100%
Medical and Surgical Outcome Review Programme	N/A	Yes	100%
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit	Yes	100%
National Adult Diabetes Audit (NDA)	National Pregnancy in Diabetes Audit	Yes	100%
National Adult Diabetes Audit (NDA)	National Diabetes Core Audit	Yes	100%
National Asthma and COPD Audit Programme (NACAP)	COPD Secondary Care	Yes	100%
National Asthma and COPD Audit Programme (NACAP)	Pulmonary Rehabilitation	Yes	100%

National Programme Name	Work Stream/ Topic Name	Should we Participate?	Case Ascertainment
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	Yes	100%
National Asthma and COPD Audit Programme (NACAP)	Children and Young People's Asthma Secondary Care	Yes	100%
National Audit of Care at the End of Life (NACEL)	N/A	Yes	100%
National Audit of Dementia (NAD)	N/A	Yes	100%
National Cancer Audit Collaborating Centre – National Breast Cancer Audit	N/A	Yes	100%
National Cardiac Audit programme (NCAP)	National Heart Failure Audit (NHFA)	Yes	100%
National Cardiac Audit programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Audit programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Child Mortality Database (NCMD)	N/A	Yes	100%
National Comparative Audit of Blood Transfusion	2023 Audit of Blood Transfusion against NICE Quality Standard 138	Yes	100%
National Comparative Audit of Blood Transfusion	2023 Bedside Transfusion Audit	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	N/A	Yes	100%
National Emergency Laparotomy Audit (NELA)	N/A	Yes	100%
National Gastro-intestinal Cancer Audit (GICAP)	National Bowel Cancer Audit (NBOCA)	Yes	100%
National Gastro-intestinal Cancer Audit (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
National Joint Registry	N/A	Yes	100%

National Programme Name	Work Stream/ Topic Name	Should we Participate?	Case Ascertainment
National Lung Cancer Audit (NLCA)	N/A	Yes	100%
National Maternity and Perinatal Audit (NMPA)	N/A	Yes	100%
National Neonatal Audit Programme (NNAP)	N/A	Yes	100%
National Ophthalmology Database (NOD)	National Cataract Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	N/A	Yes	100%
National Prostate Cancer Audit (NPCA)	N/A	Yes	100%
Perinatal Mortality Review Tool (PMRT)	N/A	Yes	100%
Perioperative Quality Improvement Programme	N/A	Yes	100%
Sentinel Stroke National Audit Programme	N/A	Yes	100%
Serious Hazards of Transfusion UK National Hemovigilance Scheme	N/A	Yes	100%
Society of Acute Medicine Benchmarking Audit	N/A	Yes	100%
The Trauma Audit & Research Network (TARN)	N/A	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	N/A	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	N/A	Yes	100%

National Confidential Enquires into Patient Outcomes and Deaths (NCEPOD)

Study Title	Participation	Project Status	%
Testicular Torsion Study	Yes	Submitted	87.5
End of Life Care	Yes	In Progress	33
Endometriosis	Yes	Submitted	60
Juvenile Idiopathic Arthritis	Yes	In progress	0

At the time of writing the NCEPOD studies for End of Life Care and Juvenile Idiopathic Arthritis are still underway and therefore the percentage of submission given is not the final figure.

Non- Participation/Exceptions

Improving Quality in Crohn's and Colitis (IQICC) – The Trust's Electronic Health Record, Cerner, is not able to update the registry to submit data, there is a significant cost implication to this. There is a risk on the Trust Risk Register to highlight reasoning for non-participation.

National Diabetes Footcare Audit – unable to participate in audit due to staffing capacity issues.

National Cardiac Arrest Audit – no participation due to staffing, currently under review for participation 2024/25

Outcomes and Learning from Clinical Audits Undertaken During 2023/24

The number of clinical audits both national and local which formed part of the 2023/24 Audit Plan are as follows:

Total Number of Audits in 2023/24 plan	Number of Local/Other Audits	Number of National Audits 2023/34 Including NCEPOD	National Audits from Previous Years (reports not yet reduced)	Number of Audits Fully Completed
356	262	49	45	101

Some of the key learning from 2023/24 is as follows:

National Joint Register 20th Annual Audit

WUTH performs primary hip, knee, shoulder and ankle replacements. We also perform revision hip, knee and shoulder procedures. The implant selection, the fixation type (cemented/uncemented) and the bearing surfaces (metal on polyethylene, ceramic on polyethylene, ceramic on ceramic) are all widely used cohorts and appear to be performing within the normal distribution curves i.e. our implant selection appears appropriate and in-keeping with most units. The unit data with regards 90-day mortality after arthroplasty surgery shows us within the normal range and not an outlier. The unit performance with regards 5 and 10 year survivorship of implants for hip and knee

arthroplasty appears to show us within the normal range and not an outlier.

UK Parkinson's Audit 2022

Key Successes - 100% of all patients were seen within 12 months of their last review which is good practice. With attention to End-of-Life Care, advanced care planning was much improved from last year and compared to other services nationally, WUTH = 50% National = 37.5%.
From feedback from the patient survey, we are performing well in screening patients for non-motor symptoms and safe prescribing and monitoring. Giving good information on Parkinson medication and in particular dopamine agonists when prescribed and monitoring for adverse effects and driving impact.

Our Parkinson Disease nurse service, clinicians service and physiotherapy services all received very positive feedback – with greater than national % of responses scoring as excellent or good. This year we audited a greater number of patients (n= 66 cases) compared to previous years (n= 30–40).

Key Concerns - Some standards are challenging to achieve and relate to understaffing and lack of commissioned services such as reduced access to Specialist Occupational Therapy services for patients with Parkinsons Disease. NICE CG71 advises that all Parkinson Disease patients should have access to an Occupational Therapist with specialist experience. Short staffing in psychiatry and absence of any commissioning for in-hospital psychology services to support this aspect of the service.

Actions:

- Develop key signposting guidance and timely referrals to additional third-party services.
- Improve dissemination of contact details for WIRED and local advisers
- Improve sharing of regional and national research projects in Parkinson Disease.
- Improve recording of FRAX/Qfracture score and participation in bone health QI.

National Audit of End-of-Life Care.

Key Successes – Good at recognising patients who are in the dying phase, discussing the possibility of dying with families and others, having DNACPR conversations, good initial assessment and individualised care, good oversight of hydration management, development and training of staff and support for non-specialist staff supporting end of life care

Key Concerns – Further work required on prediction and documentation of patients moving into imminently dying, improving further follow up conversations with family, need better documentation around bowel and bladder function and care, reducing unnecessary invasive tests whilst in dying phase, need to improve up take of role essential end of life care training and lack of side rooms for patients at end of life.

Actions:

- Communication in last days of life (CILDOL) teaching to be implemented with Junior doctors
- Improve recording of uncertain recovery
- Trust-wide escalation treatment plan built into Cerner

Falls and Fragility Fracture Audit Programme (FFAP) National Audit of Inpatient Falls (2022)

In line with the national audit criteria, there are 6 recommended standards for the assessment of patients over the age of 65 as a comprehensive multifactorial falls risk assessment (MFRA). This involves a score of 5 out of the 6 parameters being classed as a high-quality assessment and anything below a score of 5 to be classed as a poor assessment.

The 6 assessment standards which should be documented include the following;

1. Perform a line and standing blood pressure
2. Undertake a vision assessment
3. Delirium assessment
4. Review medication for impaired heart or the brain function
5. Continence check
6. Mobility assessment

The trust submitted data to the National Audit of Falls, received specific data on 8 case notes of patients that had fallen and sustained a femoral fracture, and these results are aligned to the national falls assessments. The trust is currently being assessed on 4 parameters for these cases which include;

1. MFRA quality score
2. Cases where patients were checked for injury before being moved
3. Cases where safe manual handing method was used to move a patient from floor
4. Cases that received a medical assessment within 30 minutes of a fall

Key Successes – The trust position has provided assurance for standards 1 and 4 performing above the overall compliance rate.

Key Concerns- Against the national standards, the trust was not compliant in standards two and three.

Actions:

- intelligence and data gathering of falls cases should be aligned and reviewed against these standards on a regular basis in order to compare against the national standards.
- falls benchmarking data should be added as a monthly agenda item to help the trust benchmark against national standards and help to drive the areas of improvement
- significant areas of improvements against the standards should form part of the divisional improvement plans and align with the trust policy

FFFAP - National Audit of Inpatient Falls (2023).

Falls prevention remains a high priority for WUTH. Restructuring of falls prevention group to review monthly progress in line with national inpatient falls recommendations.

KPI 1: High-quality multi-factorial risk assessment (MFRA) prior to the fall 0%
KPI 2: Check for injury before moving 75%
KPI 3: Flat lifting equipment used to move the patient from the floor 25%
KPI 4: Medical assessment within 30 minutes of the fall. 100%

When looking a numbers of hip fractures sustained as an inpatient fall, the Trust is currently 5% (England average 2.8%, North West range 0% to 7.5%). This places the Trust joint second highest trust for hip fractures sustained as an inpatient.

Actions:
The Trust holds a Falls Patient Safety Steering Group and the action plans from this group include improvements in timely Multi-factorial falls risk assessment, prevention of falls with patients most likely to sustain significant injury (such as hip fractures) and safe movement and lifting post fall.

National Paediatric Diabetes Audit.

Key Successes: Median HbA1c improved from 63.5 to 62.8 mmol/mol during the audit reporting. There was a marked improvement in key care processes from previous year and the overall completion rate was above national average. Similarly additional health checks rate was above national average and there was 100% compliance with screening bloods and carb counting at diagnosis. Other successes included; Dietetic support and psychological screening rates (above national average), reduced microalbuminuria prevalence rates, reduced emergency hospital admissions

Key Concerns: The main concerns from the audit noted; a worsening deprivation profile, higher rates of obesity and high BP, low rates of real time Continuous Glucose Monitoring (CGM) and pump use

Actions:

- Consider expansion of psychology services
- Pump start marathon aided by technology bid funding from NHSE
- Consider longer clinic appointments to support patients undertaking CGM
- Consider diabetes educator appointment
- Capacity/demand review and business case

National Diabetes Core Audit

The National Diabetes Audit (NDA) provides a comprehensive view of diabetes care across health economies in England and Wales. It measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards.

NICE guidance is based on evidence that regular systematic review of people with diabetes and achievement of glucose, blood pressure and cardiovascular risk standards maintains health and reduces long term complications. The NDA enables NHS services and organisations to:

- assess local practice against NICE guidelines
- compare their care processes, and care outcomes, with similar services and organisations
- identify gaps or shortfalls that are priorities for improvement.
- track responses to change programmes
- identify and share best practice
- provide a comprehensive national picture of diabetes care and outcomes in England and in Wales

This year's report highlights three 5-year trends

- Impact of the pandemic on care delivery from 2017-18 to 2021-22
- Health inequalities in routine diabetes care from 2017-18 to 2021-22. Includes variation in whether people received all relevant care processes and person characteristics associated with this variation to support services to tackle inequalities.
- Treatment target achievement in people with type 1 diabetes and type 2 and other diabetes from, 2017-18 to 2021-22

Within the Cheshire and Merseyside Integrated Care System 38% of people are receiving all 8 NICE recommended care processes for Type 2 diabetes, with 27.7% receiving all 8 NICE recommended care processes for Type 2 diabetes. Out of the 8 care processes Urine albumin was the lowest compliance for both Type 1 (41.6%) and Type 2 (50.3%).

Local Audits.

The reports and outcomes of 101 local clinical audits were reviewed within 2023/24 at directorate meetings.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Acute Medicine	AC222303	Management of collapse Transient Loss of Consciousness (TLoC) in the ED	253 patients audited of these 81 (32%) were admitted to hospital. Of those admitted 44 (54%) had abnormal ECGs and 16 had no positive findings across ECG, examination, and investigation. 3 patients were referred for inpatient cardiology review. 2 patients were already known to cardiology at WUTH or LHCH and had implantable cardioverter-defibrillator/ permanent pacemaker discussed with them previously. 11 of the admitted patients had a device fitted. Data from the audit is to be used by cardiology to look at developing a syncope clinic.
Acute Medicine	AC222308	Assessing Compliance for Follow up Chest Xray (CXR) in Pneumonia	Focus was placed on 2 main departments within the Trust, Emergency Department and General Internal Medicine. In total 100 patients were audited retrospectively. Detection rates were higher in the Emergency Department at 58% compared to Medics 35% and none at 7%. Out of 100 patients 35 (35%) had a follow up chest x-ray requested. There were 75 patients admitted under internal medicine 32% of these patients had a follow up request however 20% of these has no repeat chest x-ray. 25 patients were admitted under the emergency department with 40% of patients having a follow up request however 25% of these had no repeat chest x-ray. Work is ongoing to increase awareness about the important of repeat CXR in patients with pneumonia to members of staff and visuals aids are now prominent in the emergency department and internal medicine.
Acute Medicine	AC222309	RE-AUDIT: Establishing a time-frame involving the antibiotic administration, blood cultures collection and obtaining serum lactate in patients with probable sepsis.	Improvement in the compliance of blood culture collection from almost 66% to 73%. More blood cultures were taken for patients with red flag sepsis alert - 65% compared to 58% previously. Sepsis confirmation form was signed for 70 patients with no blood cultures taken. Collected a smaller number of blood cultures in patients who had a sepsis Dx compared to cycle 1 - 85% compared to 92%.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Acute Medicine	AC222313	Lymphocytopenia in COVID Patients	The study showed a clear link between having lymphopenia and severe disease, this might aid the triage process. The link is evidenced by the clear increase in % of patients needing O2 therapy and ITU treatment. Lymphopenia is associated with severe COVID 19 infection and worse outcomes. This can potentially inform clinicians re management options and early escalation. Learning has been shared with the team.
Acute Medicine	AC222314	MSCC Compliance Re-audit	The results from the audit show there is a difference in prompt diagnosis, treatment and management of metastatic spinal cord compression (MSCC). Difference between patients presenting to hospital and those who develop MSCC during admission: - Over half of patient who develop MSCC during admission did not have a diagnosis of cancer prior to admission. - Increased numbers of patients in hospital are diagnosed with MSCC following an incidental finding on imaging. - Significant reduction in having a definitive treatment plan in place if not presenting with MSCC. - Loading doses of dexamethasone are more likely to be delayed until the MRI has been reported for patients who develop MSCC during their admission. These differences may well be due to the challenged in diagnosing impending MSCC or when patients have no prior diagnosis of malignancy. There were several patients the oncology or palliative care team identified as possible MSCC that the treating team did not treat as this until an MRI confirmed the clinical suspicion. Since 2021 there has been improvement in - The no. of patients having their investigations & management guided by the MSCC coordinator, and in particular within 24 hours - Ongoing proactive involvement early on in patient's admission from the palliative care team, including early recognition from the treating teams of the benefit from this.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			- Timely prescription and administration of dexamethasone for patients with high clinical concern of MSCC prior to their MRI - Improved documentation of a plan for dexamethasone weaning and monitoring following the introduction of a template for dexamethasone used by the palliative care team to document these details There is still room for improvement with - Increased awareness of the management of patients with MSCC in the non-assessment wards, with 81% of those diagnosed with MSCC during their admission being under the care of the medical teams rather than Acute Medicine/ED - BM monitoring both during hospital and communication for discharge for patients who are dexamethasone remains poor - When bed exercises are documented as being appropriate, there is then very limited documentation. Trust wide education is underway for identifying patients at risk of MSCC and managing them with an MSCC co-ordinator with urgent MRI and high dose dexamethasone. Ongoing work with link AHPs re the importance of early intervention for patients with MSCC. Discussion is taking place with pharmacy around safety netting for dexamethasone monitoring and discharge TTH letter including BM monitoring. Impending MSCC recognition and management is to be included in Junior Doctor Teaching.
Blood Science	CSD232404	National Audit of Antenatal Sickle Cell and Thalassemia Screening	All pregnant patients are eligible for screening and should be tested at the first antenatal appointment by 10 weeks. Wirral University Teaching Hospital is a low prevalence Trust with 2% of the booking bloods screen positive. In low prevalence Trusts a Family Origin Questionnaire (FOQ) is used to assess the risk of the parents being a carrier. If a sample is received in the trust without an FOQ there is a risk the patient will not be screened for sickle cell disease. Of the 3037 samples received 3131 (97%) were received with an FOQ. 39 (1.25%) of these had an incorrect FOQ and 53 (1.7%) had no FOQ. 2 Patients declined the

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			submission of a FOQ. However, it is to be noted that although 94 patients had the incorrect or no FOQ the samples were still tested for sickle cell. An UKAS Extension to Scope for new sickle cell testing equipment has been agreed and has been added to the current scope. Prevalence is monitored through the quarterly returns and the departmental quality meeting.
Radiology	CSD232416	CT WHO Checklist Re-audit Q1	As part of CT compliance with NatSSIPs, we conducted a WHO audit using theatres '5 Sequential Steps' Audit tool. All 9 elements of the audit achieved 100% compliance.
Radiology	CSD232417	IR WHO Checklist Re-audit Q1	7 elements audited achieved 100% compliance. The following 2 elements achieved 94% Compliance. - Distractions - Team response to focused silence Documentation in and around restarting anticoagulation has greatly improved, interventional radiographers continue to remind the radiologists of its importance for patient care. Working alongside the vascular surgeons and SEAL pharmacist has assisted in improving our compliance. Medical staff are being encouraged to leave messages to further reduce interruptions, the radiology CSW is continuing to take messages to avoid interrupting during IR procedures.
Radiology	CSD232418	MRI WHO Checklist Re-audit Q1	As part of MRI compliance with NatSSIPs, we conducted an MRI WHO audit using theatres 'Sequential Steps' Audit Tool. 12.5% of performed cases were observed. 6 of the 7 elements achieved 100% compliance. Interruptions were the non-compliance however compared to Q4 interruptions were notably less. The importance of not interrupting has been reiterated to staff and is discussed at regular staff huddles.
Radiology	CSD232419	Fluoroscopy WHO Checklist Re-Audit Q2	The key success noted from the audit are: - Both sections of the audit showed excellent compliance achieving 100% - Old versions of the checklist were removed. - Training and awareness for staff completing forms was given. - Clear blank copied of the checklists are readily available.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			- Staff stopped procedures if patient was on anticoagulants. - Staff checked allergies and site of the procedure with the patients prior to the procedures and documented this. One concern of note is the 'designation' has now been replaced with 'role'. All procedures are undertaken in Room 2 Radiology, and this should ideally be documented in the title in case of confusion with Interventional procedures. Due to this the title of the checklist was amended to highlight the room.
Radiology	CSD232421	Audit IRMER Operator Compliance with Employer Procedures – X-ray and Fluoroscopy	100% compliance was seen with justification for patient ID, and Inclusive Pregnancy Status (IPS), for all exams included in this audit. IPS compliance improved from last audit, increasing from 50% to 100%. For this audit period more areas were included in the data collection. Arrowe park was the only site that was audited, the community sites have not been audited on this occasion. Community staff do not rotate to Arrowe Park so there is no assurance for the compliance levels in these sites. Community sites to be included in the audit going forward. Although compliance has improved, exposure factors and dose still not 100% compliant (both 98% compliant). It is to be noted due to ageing equipment that kit downtime does not allow for dose to always be available. Education is on-going through staff huddles and newsletters.
Radiology	CSD232422	Audit of IR(ME)R Employers Procedure Compliance - CT	All standards within the audit achieved 100% compliance. Audit is repeated quarterly to have a more robust process and real time monitoring.
Radiology	CSD232423	Audit of IR(ME)R Employers Procedures Compliance – Breast	All standards within the audit achieved 100% compliance. Audit is repeated quarterly to have a more robust process and real time monitoring.
Radiology	CSD232424	Audit of IR(ME)R Employers Procedures Compliance IR	All standards within the audit achieved 100% compliance. Audit is repeated quarterly to have a more robust process and real time monitoring.
Radiology	CSD232427	Re-audit of Partial Mammography at Wirral Breast Screening	Rate of partials has declined to below 1% (0.64%) but remains higher than the national average. Rates were compared between partials prior to an education session (0.93%), with after the education session (0.64%), which showed a positive correlation. Patients with pacemakers or restricted movement had the highest rate of partials.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			The rate of partial mammograms is monitored via a national audit - therefore an inhouse re-audit will not be required, unless concerns are raised. A continued professional development session is to be planned in for all mammographers.
Radiology	CSD232437	The Use of PI-RADS v2.1 in pre-biopsy multi-parametric MRI	50 consecutive mpMRI prostate reports were analysed, patients with prostatitis and on active surveillance were excluded. Improvements in compliance have been made with extra-prostatic extension and neurovascular bundle with all 7 standards now achieving 100% compliance.
Therapies	CSD232438	Re-audit to Explore the Occupational therapy Role in the Assessment, Prevention and Management of Delirious Patients in WUTH	There has been a vast improvement of Occupational Therapy (OT) input with delirium patients. The 4AT was completed by 33 therapists. The 6CIT remains to be completed inappropriately identifying further education is required regarding appropriate assessment tool. Overall, there was 61% compliance of 4Ats completed by the MDT. 31 Patients received orientation input in comparison to 7 in 2021. Family education was the most improved area of OT intervention with an increase from 12 in 2012 to 65 in 2023. Education is ongoing around types and cause of delirium, assessment tools, therapy management, family educations and awareness of community follow up services. Pathways are currently being developed for blended competencies and cognition for OT's.
Radiology	CSD232440	Spinal X-Ray Reports	The highest scoring fractures (potentially unstable) showed good concordance with the descriptors in the AO classification. However, there is now not enough knowledge of the AO classification system amongst musculoskeletal (MSK) Xray reporters. Reporters have been informed the AO classification system is to be used going forward and a reaudit will take place in the next financial year.
Cell Path	CSD232445	Review of Processing Fat from Pelvic Lymph Node Dissection	On average >10 nodes were identified macroscopically however once microscopic examination was completed all cases had a minimum of 10 nodes identified. On average 43% of nodes were identified in the fat. Some correlation between size of tissue and nodes within it as well as final node count and number identified macroscopically but not statistically significant. Current practice or processing all material from lymph node specimens to continue.

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Cell Path	CSD232446	An Audit of Reporting Of Endometrial Carcinomas On Biopsy Specimens	Recommended by Royal College of Pathology for cellular pathology departments to audit typing and grading of endometrial carcinomas on small biopsy specimens, as this provides crucial information in guiding patient management. 100% compliance was achieved for both audit standards of type and grade being included and if not, a reason why was documented. Most biopsies had p53 and ER immunohistochemistry
Microbiology	CSD232447	Blood Culture Contamination Re-Audit 22/23	Contamination rates for the Trust, when ED are excluded, remain below the 3% threshold at 2.2%. Contamination rates for the Trust excluding ED have remained consistently below the threshold since 2016/17. However, blood culture contamination rate remains above the 3% threshold for the whole Trust, at 4.2%. In ED, the contamination rate remains above the 5% threshold, at 7.6% Work to target ED, particularly to update skills and training around Blood Cultures: 1. Explore feasibility of a dedicated phlebotomist for ED 2. Delivery of clinical skills training to include blood culture collection in ED 3. Delivery of educational session on laboratory processing of blood cultures
Radiology	CSD232450	Thyroid FNA Assessment Audit	Adequacy rates for Thyroid Fine needle Aspiration (FNA) is 92%, for Non-thyroid FNA it is 93%. This remains greater than the recommended minimum of >75% stipulated by the Royal College of Pathologists. The audit found there were limited staff to facilitate capacity to meet demand including increasing demand from other non-Head & Neck Services such as penile, haematology, lung and melanoma.
Radiology	CSD232453	Biopsy Request Re-Audit	76% of Intervention Radiology (IR) and 75% of CT requests included the biopsy location within the request. In comparison to the previous audit some improvement has been noted in the precision of lung biopsy requests. The total number of IR requested have declined since the last audit however this is not truly comparable due to a smaller data set previously. Vetting times of requests for both IR and CT will have increased because of biopsy sites not being clearly stated, 25% for IR and 29% for CT. Additional time would

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			have been required to vet these requests. In many cases there were multiple sites mentioned on the request making it difficult to determine what was required which could have resulted in error.
Therapies	CSD232455	2022 UK Parkinsons Audit Physiotherapy	National audit showing overall good results, with areas for improvement identified. - Not all patients had a management plan on discharge. - Not all patients were aware how to contact the team. - Balance and strength exercise classes had not been restarted since covid, due to space issues. - Some outcome measures widely used by other Trusts not used currently at WUTH. Going forward all patients will be given a management plan at the end of each episode of care with the team contact details clearly documented. Exercise classes have now been restarted for balance and strength for patients attending neuro outpatient's physio department. The 10-metre walk is not as informative timed up and go tests (TuaG) so not used with every patient.
Radiology	CSD232457	A Clinical Audit of The Effectiveness Of The Fast-Track System For Identifying Suspected Lung Cancer On Chest X-Ray Images	The fast-track system is working effectively and being well implemented in this radiology department. The reporting radiographers and radiologists are working to the same standard which is a positive conclusion in favour of the reporting radiographers. This clinical audit supports the argument that more reporting radiographers should be trained to help assist with the workload of plain X-ray image reporting.
Radiology	CSD232459	The use of PI-RADS v2.1 in pre-biopsy multi-parametric MRI (re-audit)	All standards within the audit achieved 100% compliance. It is of note that the prostate reports are of a high quality.
Blood Science	CSD232460	2022 National Comparative Audit of Blood Sample Collection and Labelling	99.2 % of samples taken for transfusion bear all core patient identifiers (first name, last name, date of birth and unique identification number) 100% of the transfusion request forms were completed with all core patient identifiers (first name, last name, date of birth and unique identification number) 100% of all core information on sample tubes and request forms was legible. 98.6% of all core information on sample tubes and request forms matches.

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Blood Science	CSD232463	Audit of ED Point of Care Testing (POCT) Coordinators non-conformities when adding new operators into the Aqure Middleware	1199 operators were audited 99 % of these had required certification expiry date, as per POCT policy. From the 1199 operators, it was identified that 14 operators had been added to the Aqure middleware POCT between 2019-2021 without certification expiry date which is normally 2 years. Of those 14 operators, 4 had used their barcode within the last 3 months. The remaining 10 added operators have not used the barcodes since before 2021 All 14 operators identified have been deactivated.
Radiology	CSD232464	Audit of Departmental IR Guided Biopsies	Department performing at Royal College of Radiologists (RCR) standards 80-90% – 90% specimens deemed adequate. 15 (10%) biopsies were deemed inadequate. A higher rate of failure in CT guided biopsies (12/83 inadequate) than USS guided biopsies (3/72 inadequate). Lung biopsies - highest chance of failure (6/15). Suggested Improvements included recording biopsy needle type & size - any correlation between different types and failure rates. A future re-audit can record size of lesions biopsied ~ correlation with failure rate.
Radiology	CSD232465	CT WHO Checklist Re-audit Q2	100% compliance noted in 8 aspects of the checklist. Non-compliance in one procedure within accurate documentation.
Radiology	CSD232466	Audit of IR(ME)R Employers Procedures Compliance CT	All standards within the audit achieved 100% compliance. Audit is repeated quarterly to have a more robust process and real time monitoring.
Radiology	CSD232467	MRI WHO Checklist MRI Q2	100% compliance noted in 6 out of the 7 standards audited. Non-compliance in one procedure was due to interruptions – however very few interruptions were noted during this audit. This was noted to be due to portering staff attempting to bring patients to the room, instead of the required ultrasound room. It has been reiterated to Porters the importance of reading CAPMAN Information.
Therapies	CSD232468	Audit of Therapies Supervision Provision	100% of supervisors had 18 months – 2 years postgraduate experience and over 50% were recording supervision sessions. 93% of rotational

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			staff who responded to the survey were meeting the frequency of supervision standard. Over half of supervisors who responded reported that they had received training. 51% were not meeting minimum standard of frequency of supervision with a large portion of this coming from the band 7 workforce. Low number of supervision contracts being completed. There were gaps in all, but one area of the standards identified. Therapies supervision standard operating procedure (SOP) requires updating reflecting the new appraisal and check in process, supervision policy and supportive for both rotational and static staff.
Therapies	CSD232469	To investigate the effectiveness of joint and soft tissue injections performed in Physio led MSK clinics'	Overall, for all areas injected the average improvement in pain was 63% with function much or very much improved by 78% of patients. Compliance with Patient Group Direction (PGD) was 100%
Therapies	CSD232470	Oesophageal Stent Placement In Individuals Diagnosed With Oesophageal Cancer April 2021 – March 2022	73% of patients had stent placed within 10 days of decision to place the stent. With 67% of patients were referred for dietetic advice - all these patients were provided with an assessment and information. 91% of patients who received dietary advice were seen within 2 days of stent placement and 42% of patients were referred to the SALT service. 33% of patients were not referred for dietary advice/service.
Radiology	CSD232473	IR WHO Checklist Re-audit Q1	100% compliance achieved in 8 of the observed elements. Compliance has increased to 100% in Team response to focused silence. 94% Compliance observed in the following elements audited: Distractions. Medical staff continue to be encouraged to leave messages where possible.
Radiology	CSD232474	Audit of IR(ME)R Employers procedure Compliance – IR	All standards within the audit achieved 100% compliance. Audit is repeated quarterly to have a more robust process and real time monitoring.
Radiology	CSD232478	Renal Cryoablation – July 2023 Updated	In total 13 patients were audited; 10 patients have no disease recurrence. 1 patient had a haematoma which presented 5 days post cryoablation, 1 has a pseudoaneurysm and is under follow up, 1 was inadequately treated and is being worked up for radical nephrectomy. The

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			remaining 2 patients have not attended follow up imaging appointments.
Radiology	CSD232479	Recovery Post Targeted and Non-Targeted Renal Biopsy	30 patients were audited, and all had stable observations for 4-6 hours post biopsy. No immediate complications were recorded within first week. Frequency of complications with 2 hours bed rest will be reassessed and the recommended bed period reviewed. Re-audit will be completed in the next financial year.
Therapies	CSD232480	An Audit to Assess Whether GP Practices in the Wirral Offer Registered Patients with Gluten-Sensitive Enteropathy, Including Coeliac Disease, Gluten Free Foods on Prescription	Out of the 50 GP practices 5 (10%) completed the questionnaire. 100% of respondents offer gluten free prescriptions. Due to the low response rate the conclusions that can be drawn are limited. Further audit to be conducted to increase sample size. Liaise with coeliac lead consultant to ascertain best method of communicating with GPs. Further audit involving individuals with coeliac disease to see whether the access gluten free prescriptions and what barriers they might face.
Radiology	CSD232483	Audit of IR(ME)R Employers Procedures compliance - IR (Q1 Jan 24)	Compliance rates are: Justification 95% ID 100% LMP 90% compliance. This is also on Cerner and is checked as part of the WHO checklist audit so assured this is complete. Dose Results – 95% compliance The importance of the correct documentation within the correct fields has been reiterated. Reinforced message to comply with process introduced via staff meetings following each data gathering period. Audit is repeated quarterly to have a more robust process and real time monitoring, this will continue permanently.
Radiology	CSD232487	Awareness of radiation risks among foundation doctors	Post teaching session questionnaires demonstrated increased knowledge of radiation risks. Knowledge regarding radiation risk is inadequate overall - pre-teaching session questionnaire demonstrated this. The sample size was small, so may not be representative. Further F1 teaching sessions are to be undertaken. Other educational materials are to be reviewed to establish if they can be utilised to increase and enhance knowledge of radiation risks
Radiology	CSD232489	Re-audit of 'Minimising Radiation	Average number of vertebral levels from when the scan commenced to the upper pole of the

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		Dose in computed tomography of kidneys, ureters and bladder (CT KUB)'.	kidney improved from 2.36 to 1.43. Average radiation dose in this audit improved from 304.13 mGy-cm to 198.86 mGy-cm. NDRLs for CT KUB: DLP 290 mGy cm. Coverage 61 out of 98 the scans commenced at the accepted practice range of T10-T12. 35 out of 98 started above T10. 1 out of 98 started at L1.
Radiology	CSD232490	Audit of IR(ME)R Employers Procedures compliance - CT	All standards within the audit achieved 100% compliance. Audit is repeated quarterly to have a more robust process and real time monitoring.
Radiology	CSD232491	Audit of FNA Adequacy for ENT Ultrasound	The overall adequacy rate was above target with Thyroid Fine Needle Aspiration (FNA) only highlighting one inadequate rate. Adequacy rate for FNA of anything other than a thyroid nodule is lower than target, however from nodes it is high. A caveat to this is a high proportion of these negative results were from non-specific findings. They are unlikely to yield a specific cytological diagnosis
Therapies	CSD232492	Oesophageal Stent Placement in Individuals Diagnosed With Oesophageal Cancer Re-Audit April 2022 – March 2023	The majority of patients audited had clear documentation detailing indication for the stent. With 71.4% of patients had a stent placed within 10 days of assessment. 53% of patients were documented as referred to a dietitian following placement and all except one patient received the required written patient information. There is no documentation around why the one patient did not receive the written patient information. 47% patients did not have a documented referral to the dietician. In 10 cases, dietetic intervention was provided within a timely way (2 working days). Exploration of the requirement for a UGI role/general dietetic role for cancer services.
Radiology	CSD232494	SQAS Partial Mammography rate audit 2021-2023	Audit report covered 2021/22 and 2022/23 period. - 2021/22 - 25,669 patients screened, of these 241 had a partial mammogram (0.94%) - 2022/23 - 21,260 patients screened, of these 128 had a partial mammogram (0.60%), which is decrease when compared to the previous year. Wirral & Chester Breast Screening Service is still an outlier for the number of recorded partial mammograms during the latest audit period, however this has been decreased since the previous year. Wirral & Chester remain an outlier when it comes to the number of recorded partial mammograms, however the % of recorded

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			partials has decreased from 0.94% in 2021/22 to 0.60% in 2022/23. The highest reported reasons for such partial mammograms (in Wirral & Chester) include patients being unable to attain or maintain the required position, due to restricted mobility, inability to cooperate due to limited understanding of the procedure and examinations limited by a pacemaker/Hickman line or loop recorded.
Radiology	CSD232495	SQAS Ceasing in the NHS Breast Screening Programme	Wirral and Chester had no patients registered for mental capacity or personal welfare ceased. Supporting documentation was uploaded to BS select in 82.3% of all patients who ceased to attend breast screening - this should be 100%.
Radiology	CSD232497	Right Results walk through audit	The trust achieved 100% compliance in all aspects of the walkthrough
Radiology	CSD2324100	Audit of IR(ME)R Employers Procedures compliance - Breast (Q4 Dec 23)	All standards within the audit achieved 100% compliance. Audit is repeated quarterly to have a more robust process and real time monitoring.
Radiology	CSD2324105	Audit of IR(ME)R Employers Procedures compliance - CT (Q1 Feb 24)	All standards within the audit achieved 100% compliance. Audit is repeated quarterly to have a more robust process and real time monitoring.
Radiology	CSD2324106	Audit of IR(ME)R Employers Procedures compliance - X-ray & Fluoroscopy (Q4 Dec 23)	100% compliance was seen with justification and ID, for all exams included in this audit. Increased data collected compared to last audit, with more areas included. Data was gathered from all WUTH sites, increasing assurance across department. IPS, exposure factors and dose compliance has reduced. IPS may have been recorded on paper, but needs to be recorded on Cerner to be compliant
Diabetes	Med222303	Glycaemic Control In People With New Diabetes Foot Ulceration Reviewed In The Outpatient Clinic	Glycaemic control is an important modifiable risk factor predisposing to foot ulceration. The audit sample was random from an anonymised spreadsheet of new outpatients reviewed in the diabetes foot clinic. 60% of the new outpatients were diagnosed with a foot ulcer. 44.6% patients {HbA1c 71.1 (SD 26.1) mmol/mol} were managed by secondary diabetes team. 55.3% {HbA1c 74.8 (SD 22.5) mmol/mol} were managed in primary care. 52.7% patients had their glycaemic control reviewed in diabetes foot clinic. 14.5% had their diabetes medication modified in the diabetes foot clinic

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			HbA1c, 3 months before review in multidisciplinary diabetes foot clinic. Good (<59 mmol/mol) in 26.8%. Sub-optimal (60-81mmol/mol) in 41.5% . Poor (>82mmol/mol) in 31.7%. An educational poster about the importance of improving blood sugar control has been produced to further patient education and a patient information leaflet is currently in production.
Renal	Med222305	Peritoneal Dialysis Associated Infection	Peritoneal Dialysis (PD) peritonitis rate was within recommended target of less than 0.40 per for years 2020, and 2021, but above the target range during 2022. Rate of exit site infection is concerningly much higher than the expected standard, with 11.4 % of exit infections develop PD peritonitis, so it is important to manage exit site infection at the earliest opportunity. Hence, the recommendations and measures to reduce, rule out infection are required which include patients' education, refresher sessions and appropriate management of exit site with antibiotics at the earliest signs of infection. Topical mupirocin has been introduced in 2022 which may help reduce the rates of exit site infections. However, there is risk of development of Mupirocin resistance and overgrowth of gram-negative organism such as pseudomonas. This will be required to be closely monitored. The organism causing exit site infections did not always match the organisms in the PD fluid which could not be explained. Documentation of exit site was inconsistent, and this will need improvement. It is important to note the state of exit site even if it appears clean.
Palliative Care	Med222311	Patient Experience of Palliative Care Physiotherapy	It was believed that the results of the audit may have been impacted on due to a high proportion of answers question 9- making a plan was answered not applicable. It was recognised that it is not always appropriate to set goals with this patient group however will explore the use of an outcome measure used within palliative care and to repeat audit once utilised. Explorations and trialling of the Goal Attainment Scale (GAS) outcome measure and then a reaudit will take place. .
DME	Med222324	Warfarin prescribing Audit	The audit has identified opportunities for better working between pharmacy and medical teams to

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			increase the discussions to switch to DOAC if possible. Education sessions for FY1 doctors and new doctors to Trust have been implemented. Sessions include- good management, highlighting cases of poor management, how to avoid this; good practice on admission "In hours" and "OOH" management → should have INR and Rx in working hours for 6pm admin, plans for weekend
Diabetes	MED232427	Management of inpatient diabetes foot disease by the multidisciplinary diabetes foot team	High prevalence of inpatient diabetes foot disease. 15% referrals were found top be inappropriate. Significant number of inpatients seem to have foot ulceration or develop foot ulceration after admission to hospital. High inpatient mortality and increased risk of death following hospital discharge
Gastroenterology	MED2223308	Decompensated Cirrhosis discharge bundle	The aim of the audit is to implement the decompensated cirrhosis discharge bundle (DCDB) and evaluate before and after implementation, data was collected by reviewing discharge letters and Cerner documentation. Baseline data was gathered by auditing 20 patients, the data shows that none of these discharge letters contained the patients' weight. Only 5% has discharged creatinine, sodium and potassium documented and only 10% of discharge letters contained information regarding future adjustments of diuretics. Interventions occurred between further data being collected where posters promoting juniors to complete the discharge bundle were displayed, printed copies of the DCDB were made available on the ward and juniors from the gastroenterology ward were emailed to raise awareness of the bundle. After interventions data was collected from 40 patients, discharge letters post implementation showed a 20% improvement in documentation of the patient's weight when discharged and a 5% increase in the documentation of electrolytes. However, the frequency of U&E monitoring has decreased by 10%. Similarly, there was a 5% decrease in the documentation of diuretics dose adjustments to be acted on after the patient is discharged and once ascites is controlled.

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			Non-IT based prompts, therefore, are dependent on juniors picking up when doing paperwork. Junior doctors rotate in and out of gastro all the time so ongoing education required. Action to explore the possibility of adding BASL bundles to Cerner as an IT based prompt. Education for junior doctors on DCDB, to include in junior doctor induction and gastro training.
Renal	MED232436	Retrospective Review of Chronic Kidney Disease Practice	A large proportion of patients are suitable for ongoing management in primary care, and don't necessarily need ongoing review in nephrology clinic. Too many patients are not having a urinary ACR or PCR checked in the appointment. Many patients are not being optimised on medications, whether that be ACE / ARB, SGLT2 or statins
Pharmacy	Ph232401a	Quarterly Controlled Drugs (CD)Audit	The percentage of areas 100% compliant with standards in Q1 was 76% (63/83) compared to Q4, 66% (58/88). The use of Tendable audits is a valuable improvement tool. Real time feedback at ward level is supporting continuing education with standards, and the monthly Tendable CD paper reviewed at MSOP is providing visibility to drive performance. Improvement work continues to be required to deliver full compliance with the CD regulations consistently in all areas. Key area of non-compliance is: Required information missing in the CD record book. Each division have their own Controlled Drug risk with individualised actions, which are led by the ADNs.
Pharmacy	Ph232401b	Quarterly Controlled Drugs (CD) Audit	The percentage of clinical areas 100% compliant with standards in Q2 was 75% (62/83) compared to Q1, 76% (63/83). The use of Tendable audits is a valuable improvement tool. Real time feedback at ward level is supporting continuing education with standards, and the monthly Tendable CD paper

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			reviewed at MSOP is providing visibility to drive performance. Improvement work continues to be required to deliver full compliance with the CD regulations consistently in all areas. Key areas of non-compliance are: - Required information missing in the CD record book. - Mistakes amended inappropriately. Each division have their own Controlled Drug risk with individualised actions, which are led by the ADNs.
Pharmacy	Ph232404	Medicine Storage Audit	The overall results of the audit were positive with many areas of good practice. No individual wards have been highlighted as a cause for concern. 40% air tube stations found unlocked and a third of wards had medicines left out on surfaces within medicines rooms. Other key issues identified: - Worsening condition of storage facilities. - Low availability of lockable drawers in the computer-on-wheels used for medicines administration. - Insufficient storage for gases. - Visibility of expiry dates of crash boxes on emergency trolleys difficult to view. - Lack of standardised storage of potassium containing fluids
Pharmacy	Ph222304	Antibiotic Point Prevalence	Compliance with the Trust antimicrobial formulary (or otherwise appropriate documented deviation) was 91% across the Trust. Within the divisions, compliance was 94%, 90% and 91% in Divisions of Surgery, Medicine and Women & Children's respectively. 92% (306/333) of eligible prescriptions have received an antibiotic review within 72 hours of initiation. Of the 27 prescriptions that did not have a review, 21 had been prescribed for less than 72 hours and were still eligible for a review. The proportion of IV antibiotics was 49% and although this figure is less than the previous year's audit, benchmarking against other Trusts has shown that we have a high proportion of IV antibiotics to oral. A total of

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			30 prescriptions were deemed inappropriate deviations from the formulary.
Pharmacy	Ph222305	Vaccine Cold Storage	Pharmacy, CGH and APH wards and departments were 100% compliant with NPSA requirements and WUTH Medicines Management policy in 11 of the 12 standards. The audit showed an improvement compared to the previous audit in January 2021. 80% compliance with electrical tests being carried out on fridges holding vaccines within the last 12 months. Maternity Ward and Maternity Day Ward were identified to have expired PAT tests and have since been re-PAT tested.
Pharmacy	Ph222306	Controlled Drugs Audit Q4	The percentage of areas 100% compliant with standards in Q4 was 66% (58/88) compared to Q3, 82% (72/88). Targeted improvement work continues to be driven across the whole Trust by PW audit results, with real time feedback being given to staff by invested area leaders. This has been underpinned by a variety of communication, shared learning and support provided by Matrons and Pharmacy. Improvement work continues to be required to deliver full compliance with the CD regulations consistently in all areas. Key areas of non-compliance are: - Failure to complete daily stock checks. - Required information missing in the CD record books. Each division have their own Controlled Drug risk with individualised actions, which are led by the ADNs.
Pharmacy	Ph222313	Pharmacist Intervention Audit	Pharmacist non-medical prescribers have the lowest rate of intervention. During the audit conducted in 2022, out of 122 prescriptions, 71 prescriptions required a pharmacist intervention, this was calculated as 58% of prescriptions. A decrease from 65% as shown in the 2020 audit data. The average number of pharmacist interventions per prescription was calculated at 1.4. The most commonly occurring prescriber error which required pharmacist intervention was missing patient details which accounted for 71% of all the interventions required. Prioritise the

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			recovery of electronic system for prescribing haematology chemotherapy. Pharmacist prescribing roles within haematology should be promoted and developed.
Pharmacy	Ph222318	Time to Prescribe Critical Medicine ED	83% of critical medicines were prescribed on admission or had a clinical reason for not prescribing documented. Only 55% of critical medicines were prescribed correctly and subsequently administered on time. No standards fully met in audit. Actions: - Raise awareness of ED critical medicine audit results and key themes that need to be addressed - Reduce missed doses of prescribed critical medicines - Improve prescribing of critical medicines in ED
Pharmacy	Ph222319	CCG2: Appropriate Antibiotic Prescribing for UTI in adults aged 16+	Q1 - WUTH achieved an overall score of 52% across all the quality measures. The delivery plan for this financially incentivised CQUIN is the development of a Cerner Millennium 'Powerform' to aid clinicians towards appropriate diagnosis and management of UTI. Q2 - results remain consistent with Q1 results with an overall score of 47% across all the quality measures. Prescriber Education Sessions have commenced and so an increase in compliance is expected in the next results. Q3 - WUTH achieved an overall score of 55% across all the quality measures (target>60%) The Cerner "build-freeze" has halted work on the powerform. There is also a need for a trust-wide clinical lead to advocate and lead for this project. Action: Prescriber education sessions to be completed by Lead Pharmacist Antimicrobial Stewardship
Trauma & Orthopaedics	Sur232428	Evaluation of waiting times for MRI ls spine inpatients with suspected cauda equina syndrome & validation of patients	Cauda equine syndrome is a rare surgical emergency and if missed can lead to a permanent disability. A total of 32 patients were audited and 100% of patients had an urgent MRI lumbosacral (LS) spine however only 10 of these patients (37%) met the 4 hour window for an urgent MRI.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
		MRI need with suspected ces against new guidelines.	The time between MRI advice and scan is not compliant with GIRFT guidelines and is 3 times more than the recommended time limit. No patient audited was diagnosed with cauda equine syndrome. It is noted admission rates under T&O for MRI are extremely high, invariably overstay in ward for pain management. Actions - ED focus to promote early identification and MRI request. - Proceed with MRI request if CES suspected- DO NOT wait for confirmation from Walton. - Reduce T&O admissions by bringing back patients for next day ambulatory MRI slot if same day slot isn't available. - Increase capacity for more same day AND ambulatory slots for urgent MRI scans. - Reaudit at a later stage (early 2024) to measure changes and improvement
Trauma & orthopaedics	Sur232429	Audit of CT Scans Ordered for Suspected Neck of Femur Fracture	Out of 50 scans – 10 were positive which is a 20% positivity rate, and all the patients with confirmed neck femur fracture on CT scan required surgical intervention. Despite of this fact a positive pick-up rate of 20% is acceptable for patients with suspected hip fracture with normal plain radiographs. The positivity rate has dropped down to 20 % from 40% back in 2021. Actions: - Improved documentation of hip examination by ED/ medics - Encourage physio teams to attempt mobilisation in all patients if initial XR's deemed to be normal
General Surgery	Sur232433	Clinical Outcomes of Small Bites Closure on Extraction	The aim of the audit is compare local rate of incisional hernia at extraction sites of colorectal cancer resections following small bites versus mass closure. A total of 268 resections where audited, 99 of these were open procedures and non-abdominal extraction sites. Out of the remaining 169 patients 109 had a mass closure, 20 (18.3%) later had a confirmed incisional hernia. 60 Patients had small bites and 4 (6.7%) later had a confirmed incisional hernia. 48% of the confirmed incisional hernias were confirmed within a year post procedure and a further 36% were within 2 years later. In conclusion use of the

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			small bites closure technique may reduce incisional hernia incidence at extraction sites compared to mass closure in minimally invasive colorectal cancer resections.
Ophthalmology	Sur232434	Re-Audit of Referrals to Orthoptic Rapid Access Service: Were They Appropriate?	The percentage of Rapid Access orthoptic appointments being booked correctly is improving. There is still further room for improvement to ensure patients are receiving a doctor appointment when indicated. There is a good use of Orthoptists as part of the MDT model. Action: Review communication at appointment planning to ensure patients receive a doctor appointment when required.
Trauma and Orthopaedics	Sur232436	Neck of Femur Fractures Post COVID: A Snapshot	Numbers increasing year on year. Complexity of the average patient is increasing. More patients have active or stable malignancy, delaying surgery, and increasing complexity of subsequent surgery. Staying longer in hospital – more likely to get secondary issues
Trauma and Orthopaedics	Sur232437	Referral Pattern to Soft Tissue Knee Clinic from ED	There were 361 referrals to the soft tissue clinic, 192 (53%) of these were appropriate and the remaining 169 (47%) were not. A new referral guideline has been implemented to support going forward.
Trauma and Orthopaedics	Sur232438	Fracture Clinic Waiting Times and Compliance with see Treat Discharge	General significant improvement in waiting times following introduction of e-pathway. STD Compliance has improved slightly – soft tissue ankle remains greatest issue Mean waiting times remain high (9.1 days) - however compliance has improved with British Orthopaedics Association Standards (BOASt) 72hr guidelines (17%). Further education to be given to ED staff and Cerner referral forms to be revised to prevent abuse of system.
Trauma and Orthopaedics	Sur232442	Improving the Weekend Handover	Successful demonstration of improved safety standards of new online handover page in line with RCS published guidance on safe handovers. Improved junior doctor satisfaction with new online handover page alongside improved perception of patient safety by junior doctors. There was difficulty escalating to orthopaedic senior. It was found not all junior doctors have access to online handover page and need to be added by existing user.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			F1 is to attend the morning trauma meeting going forward. Further audit to be completed in 6 months to further assess compliance.
Trauma and Orthopaedics	Sur232443	Snapshot Audit of Adherence to Theatre Etiquette	Theatre etiquette is very important in maintain professional standards, reducing surgical infections and maintaining excellence in safety and outcomes for the patients. In Clatterbridge 5 out of the 11 standards achieved 100% compared to 3 out of 11 in Arrowe Park. Theatre sterility was compromised with sluice/exit doors being used across both sites. Masks were not worn correctly across both sites with only a 25% compliance rate for Arrowe Park and an 18% compliance rate for Clatterbridge. Actions: - Ensure exit doors are locked during surgery. - Remove consumables from sluice area e.g., plaster trolley and suction liners. - Challenge poor behaviours and escalate to senior management if any pushback. - Self-awareness by all theatre team - Mention above during team brief. - Reaudit in 3 months to check for improvement
Trauma and Orthopaedics	Sur232444	National Joint Registry (NJR) Data Completion for Hip Hemiarthroplasty Surgeries for NOK Fractures in APH	First audit in the Trust measuring compliance in filling the NJR forms for hip hemiarthroplasty procedures – this is a new regulation introduced by the NJR applicable from 12th June 2023 Low compliance in filling NJR consent forms and for hip hemiarthroplasty procedures for neck femur fracture. Lack of awareness about the new NJR requirement – this mandatory regulation has been in place since 12th June 2023. Actions: - Changes to be made to hip fracture operation note powerform in Cerner to add a mandatory tickbox checking if NJR forms are completed after procedure. - Regular reminders in trauma meetings, huddles, ward rounds, post-op briefs to check form completion. - Reaudit to be completed to measure improvement in compliance once actions completed.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Urology	Sur232465	Reducing 30 day re-admission following ureteroscopy at WUTH: An assessment of model hospital data and whether stent passports are an effective solution to reducing re-admissions for stent symptoms.	Stentless ureteroscopy has a low complication rate; no patients who did not have a stent placed at their primary procedure required a nephrostomy or stent insertion upon readmission. The readmission rate is 13.7% and those that stay in have a length of stay that is 2.4 days on average.
Trauma and Orthopaedics	Sur232470	The Timing of Admission to WAFFU for Patients with Hip Fractures	According to the national guidelines outlined in Blue Book by the British Orthopaedic Association (BOA) and the British Geriatric Society (BGS) on The Care of Patients with Fragility Fractures, patients with hip fractures should have initial investigations completed, receive a nerve block if not contraindicated and be admitted to a speciality orthopaedic or orthogeriatric ward within 4 hours of presentation. This is monitored by the National Hip Fracture Database (NHFD) as a key performance indicator (KPI 0). As of 2022, Arrowe Park Hospital (APH) has a 1.4% rate of achieving KPI 0 with the national average being 6%. In APH, patients with hip fractures are admitted to the Wirral Acute Femoral Fracture Unit (WAFFU) as per local trust guidelines.
Trauma and Orthopaedics	Sur232478	Management of Supracondylar Fracture	Overall we deal very well with these injuries, and have a high number of them in out trust relative to other areas. We comply well with British Orthopaedic Association Standards (BOASt), in timing to surgery, and generally out radiographic outcomes are excellent. The wording of the guideline is found to be quite ambiguous allowing flexibility in interpretation. Documentation issues have been discussed with the team to allow for standardisation.
Perioperative Medicine	Sur232482	Cancellation on Day	Anaesthetic cancellations represent a small proportion of all cancellations on the day. Small proportion may be avoidable following systems check
Perioperative Medicine	Sur232483	Emergency Drug Usage and Wastage	Currently cheaper to use prefilled syringes for ephedrine but there are other advantages to prefilled syringes. Human factors and references to use of prefilled syringes in various literature. Environmental - no evidence we have found, but not wasting syringes/vials. There is wastage of

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			emergency drugs but exact figures are hard to ascertain. Costings even more difficult - fluctuation and unpredictability Atropine/glycopyrronium – are the highest waste and ephedrine wasted more than metaraminol.
Ophthalmology	Sur232484	Squint Surgery Outcomes	A total of 41 patients had strabismus surgery between June-December 2022 at Arrowe Park. 38 patients had horizontal squints and 3 had vertical squints. 20 of the 41 patients where adults and the remaining 21 were children. The average percentage reductions in Horizontal Squints post op 63.7 % and for vertical squints 86.9%. together the combined average is 75.3%. Out of the 41 patients, 8 patients required further management post op and 1 patient felt no perceived change in angle size. The standard is to see patients 2 weeks post op 1 and post op 2 varies depending on clinical decision, the average for post of 1 was 4 weeks to see an orthoptist. 17% of patients didn't receive post op 2. Out of the 17 patients who received an AS-20 questionnaires, 3 were completed and all showed a reduction in score meaning the squint surgery made a perceived improvement. A push is being made within the department for the completion of AS-20s and given pre op and post op 2.
Ophthalmology	Sur232485	Auditing the re-screening outcome for quality assurance of the audio-vision screening passes.	Out of 268 children that underwent the repeat vision screening, 267 children passed the vision re-screen. 99.6% compliant with current national screening standards, very low false positive rate identified. 1 child (0.37%) failed the repeat vision screening after passing the original vision screening and was referred into the Orthoptic Department at Wirral University Teaching Hospital. Their vision was confirmed to be bilaterally reduced (achieving 0.40 logMAR with either eye) and after a refraction, fundus and media check was prescribed glasses for full-time wear.
Ophthalmology	Sur232486	Audit of Compliance with WUTH Clinical Guideline on Down's Syndrome Visual Assessment; linked to NICE guidance and DSMIG clinical	All children with confirmed diagnosis of trisomy 21 referred to ophthalmology at 6 weeks. All children with confirmed diagnosis of trisomy 21 coded in Cerner using systematised nomenclature of medicine (SNOMED).

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
		guideline from the RCPaed	
Ophthalmology	Sur232487	Analysing the Low Vision Service within WUTH, including the reason for and source of referral, and the outcome of each appointment.	The Low Vision service in WUTH is led by the Lead Optometrist. The service is run both in APH and also in the community by certain high-street optometrists. The adults seen in APH in the LVA clinic are currently seen by the orthoptist. The Eye Care Liaison Officer (ECLO) in APH can liaise with patients needing to access the LVA clinic to decide where best the patient can be seen. There were 47 patients audited within the time-period. 7 of the referrals received were new and the remaining 40 were in-house referrals. Patients can choose to be seen in hospital or out in the community, if the referral was made through Cerner the LVA appointment would automatically be booked for the hospital, if the ECLO was involved in the referral the patient would have the choice of community or hospital appointment. 83% of the in-house referrals did not get triaged by the ECLO and were not given the choice to attend the community for their appointment. Moving forward any referral made through Cerner is to be triaged by the ECLO first and the patient is to be given a choice of community or hospital.
Ophthalmology	Sur232488	Optometrist led new glaucoma clinics compliance with NICE guidelines	The audit showed positive results with excellent compliance in most areas. One patient visual field and gonio exams not possible as patient had Parkinson's disease and difficulty with positioning. Letter to patients state not to drive however a small number of patients still do so dilation is not possible. Good adherence to guidance found.
ENT	Sur2324108	Assessing the patient information leaflet on Nasal Douching – is it clear, comprehensive and accurate? – QIP	Using feedback from staff and national guidelines, the patient information leaflet was updated. More information was included on why we recommend nasal douching, how to douche, and where to find more information. 100% staff agree that the new leaflet is clear, contains adequate detail and is suitable.
Obstetrics	WAC222323	Resus Equipment's (Maternity unit)	Q1 - Hospital Trust Standard of 100% not achieved. Resuscitaires April 2021 = 93% May 2021 = 91% June 2021 = 88% Neonatal Advanced airway Bags Daily check April 2021 = 92%

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			May 2021 = 95% June 2021 = 91% Q2 - Hospital Trust Standard of 100% not achieved. Resuscitaires July 2021 = 83% Aug 2021 = 73% Sept 2021 = 64% Neonatal Advanced airway Bags Daily check July 2021 = 87% Aug 2021 = 90% Sept 2021 = 79% Q1 - Continue to encourage all staff to achieve the hospital 100% standard (see full action plan) Q2 - Continue to encourage all staff to achieve the hospital 100% standard (see full action plan)
Acute Paediatrics	WAC222324	Paediatric Resus Equipment	Only area where 100% not achieved was with ODA checks. Email has been sent to ODA Team Leader to ensure machine and Airway trolley are checked daily.
Obstetrics	WAC222334	High Risk Obstetric Anaesthesia Clinic Referrals	Out of 300 referrals, 224 were referred timely. High number of late referrals - 76 Of cases reviewed - 70% the issue was identified at booking and recorded however referral was not made. 20% the issue was evident at booking but not identified. Common offenders - High BMI Neurological problems Anaesthetic problems Spinal problems Education for all antenatal and maternity staff - Infographic material describing ideal antenatal patient journey for high-risk patients highlighting what warrants referral to high-risk obstetric anaesthesia (HROA) clinic Emphasise that anyone can refer at any time and earlier is better Additional information about HROA clinic and referral pathway on learning and development page for midwives

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Additional clinics to be put on to cope with total volume and high frequency of late referrals with greater ease
Gynaecology	WAC222336	Retrospective review compliance and guidance on progesterone prescription in early pregnancy	Considering the speed with which the guidance was implemented, it was good to see that patients were being offered progesterone. Low proportion (34%) patients received progesterone that were eligible. Poor documentation regarding eligibility for progesterone therapy. Patients lost to follow up – will always happen given that patients may not continue with their pregnancy or transfer care elsewhere. GPs not able to prescribe ongoing progesterone and patients having to return to the department
Children's	WAC222342	Independent Health Assessments for Looked After Children Audit	Improvement in documentation of birth history weight, height and centiles recorded. Head circumference <2 years recorded. Emotional needs discussed. Overall good documentation Good feedback from patients and carers Actions: - Need to improve family history obtained (some improvement but remains partial) - Social care to ask family to fill in Form PH and send with referral. - Need to improve wait for initial health assessment from date of becoming children looked after (CLA) (although requests arriving late to us – should be referred within 48 hours of being CLA) - Data sets collected based on differing dates- some data collected based on date became CLA, some on date of IHA. Possibly merge databases. - Recording both when child was referred and date of appointment in data collection- Possible solution when referral printed add on date received - Aim to reduce time between becoming CLA and IHA occurring (statutory requirement) - More detail recorded on why child became CLA. - Re-discuss with social care regarding ensuring adequate family history available at review

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Community Paediatrics	WAC222343	Management of Disordered Sleep in Community Paediatrics	Documentation of melatonin initiation was generally good, with instructions provided for parents and GP. Patient referred to Koala NW for sleep service now sleeping really well. Great resources available Patients taking melatonin are not consistently being asked about sleep 91/194 47% Despite melatonin therapy, most patients continue to complain of sleep disturbance 74/91 81% 4 patients had symptoms of sleep-disordered breathing. 1 patient with T21. No consistent approach to the management of sleep disturbance Actions: - Implement guideline for management of sleep disturbance to promote consistency, NICE guidelines, and best practice. - Present audit findings at local community paediatrics meeting - Review options for sleep service- is there funding for links with local sleep service? Koala NW/The Sleep Charity. - How can we improve sleep for young people with neurodevelopmental conditions? Sensory needs, continence, bowel/bladder problems etc - Ensure medical causes of sleep disturbance are not overlooked
Neonatal	WAC222344	Use of Morphine in Ventilated Preterm Infants	Routine use of Morphine in ventilated prems <32 weeks is less when compared to 2019 (Survey, actual numbers) Morphine has known side effect with no evidence of benefit. Ventilation optimization (Babies never fight the ventilator) and non-pharmacological management should be first line. Education of staff to reduce the knowledge gap in regarding to pain. Increase risk of IVH with Morphine
Neonatal	WAC222345	Use of Nitric Oxide on the Neonatal Unit	All babies were treated with surfactant. All babies had efforts to manage blood pressure prior to starting when required. 86% of the patients survived.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Need careful consideration of adjusting the guideline or practice as most babies treated not in the recommended category. Documentation of oxygenation index and methaemoglobin poor. May be possible to improve acid base balance further prior to commencing. Highlight importance and relevance of Oxygenation index. Discuss and evaluate the role of Nitric Oxide in premature babies. Aim to correct pH prior to commencing Nitric
Neonatal	WAC222346	Re-audit of Documentation on the Postnatal Ward	100% babies had newborn and infant physical examination (NIPE) within first 72 hours – but this is the national standard. The vast majority had their NIPE status documented – even if the standard proforma was not used. Only 73% had a documented top-to-toe examination on day 1 of neonatal care on PNW Only 58.8% of reviews were documented using the standard postnatal ward proforma. Actions: - Induction – reminding new medical staff that all babies under neonatal care on PNW need: - Full clinical examination on day 1 of neonatal care - Documentation of this using the standard postnatal ward proforma - Documentation of NIPE status - Dissemination of information to medical staff/reminder - If the postnatal ward proforma is used this has a section to document NIPE status and also clinical examination (these serve as prompts?) - Recheck standards in 2-4 months' time
Obstetrics	WAC222347	Audit of Anaesthetic Staffing Levels	All sessions required were covered by the department. Elective Caesarean Section provision was by appropriately trained staff. Additional Caesarean Lists are covered on an ad hoc basis and may need to be put into job plans going forward if the overall number of lists which need to be delivered (e.g. increasing complexity and/or numbers of operations required)

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Actions: - Review of provision of elective Caesarean Section slots and determine if sufficient slots available. If required more lists. - Clinical Director to discuss with Theatres & Anaesthetics Clinical Director regarding staffing. - Discussion regarding whether additional slots to be built into lists to potentially accommodate Category 3 Caesarean Sections or continue to offer these as part of emergency provision
Paediatrics	WAC222354	Adherence to Retinopathy Prematurity Guideline	100% of babies screened on time and documented on badgernet. only 26% of babies had ROP documented on cerner. Feedback to ophthalmology re maintaining cerner documentation for all screened as well as badgernet
Obstetrics	WAC222358	Re-audit Establish the risk of preterm delivery in subsequent pregnancies following 2nd stage EMCS Re-audit	Current referral criteria to preterm birth clinic are appropriate. No evidence to suggest a significant cohort of patients at WUTH are having subsequent preterm birth following previous full dilatation CS. Our current preterm birth clinic referral criteria regarding previous full dilation CS appears to be appropriate. No further action required at present

Review of 2023/24

Clinical Audit now reports into the Clinical Outcomes Group (COG) which is strengthening visibility, assurance and allowing further divisional oversight. The governance of the audit cycle has been reviewed and tightened over the last year which will add value in the coming year and further supporting improvement works.

Divisions are responsible for their own audit forward planners with the central Governance Support Unit having oversight and reporting through COG and feeding into Patient Safety Quality Board (PSQB) It has been identified that Trust wide audit training would be beneficial to further strengthen and support auditors and allowing audit actions to be specific, measurable, achievable, realistic, and timely.

Looking Forward to 2024/25 we aim to:

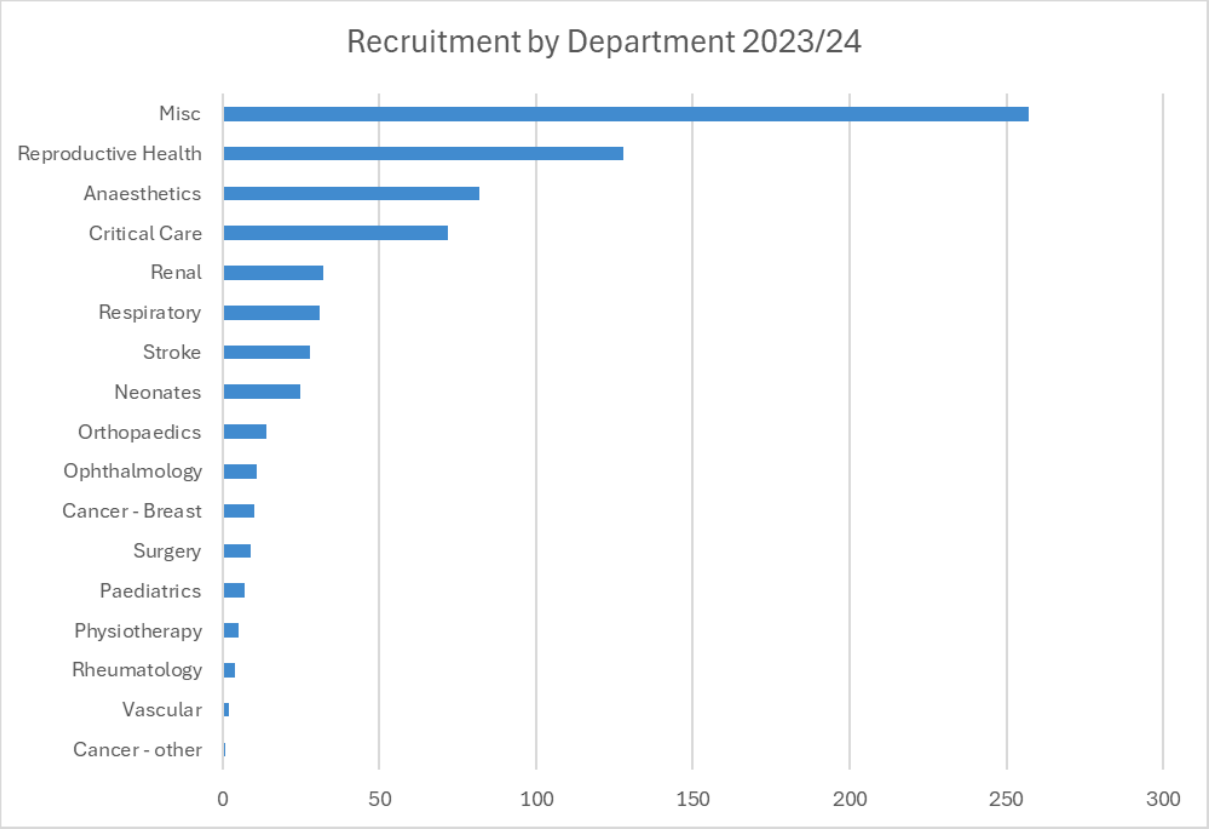
Further strengthen assurance and visibility of clinical audit within the organisation through COG and PSQB. Review and embed a process of how to share learning from audits within the Trust.

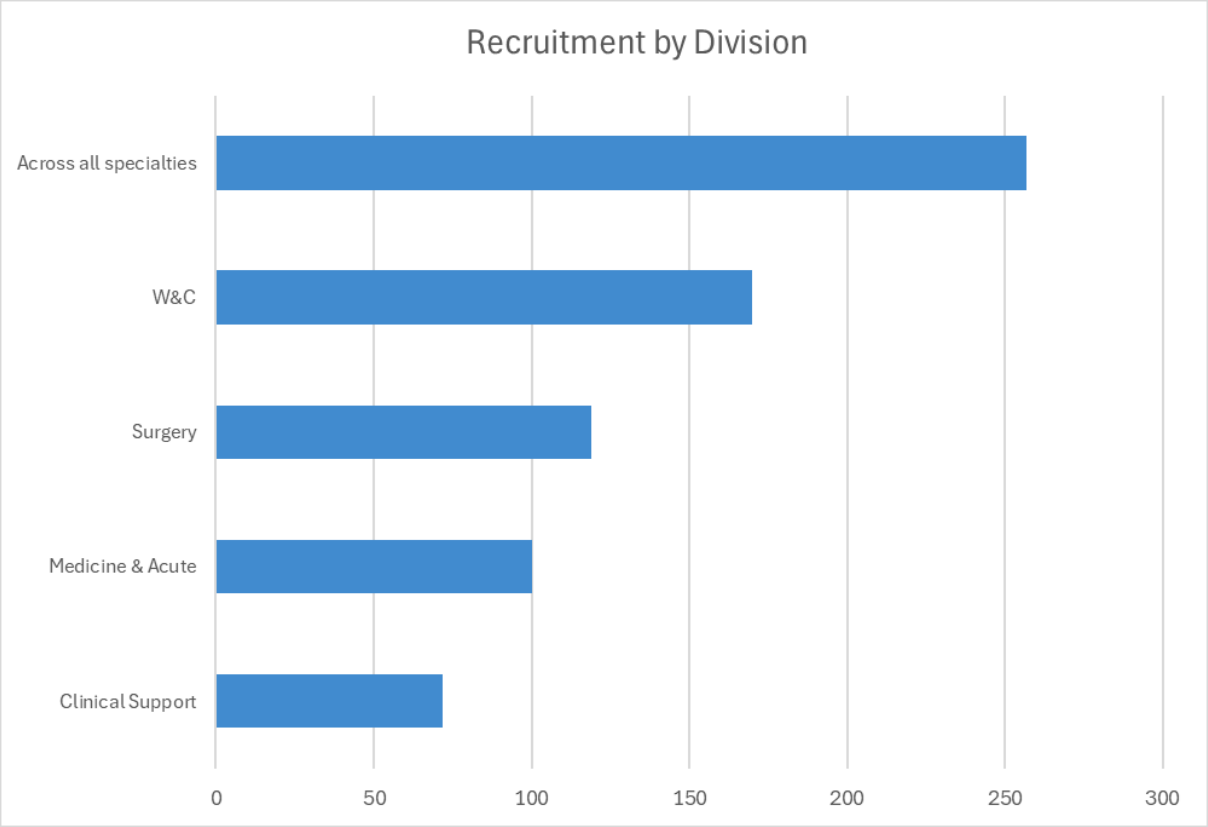
2.2.3 Participation in Clinical Research

Overview of Research Activity 2023-24

The annual target for recruitment of patients under the care of Wirral University Hospital NHS Trust (WUTH) is 700 and the research team are pleased to have met this with recruitment of 740 at the end of the financial year. All studies are on the National Institute of Health Research (NIHR) portfolio.

By Division, Women's and Children have shown most activity, particularly in reproductive health, and Critical Care has also increased activity this year. However, it was an observational study of Loneliness which contributed most significantly to accrual for the Trust. Please see charts below.





Review of portfolio

The NIHR set up the portfolio Research Reset program post COVID -19 to review studies which had been put on hold or postponed during the pandemic. As a result of this a number were closed nationally, but there were also studies on the WUTH portfolio which were still open but were not performing well. Therefore, the portfolio has been rationalised and 15 studies were closed after discussion with Principle Investigators (PI) and sponsors. Internal monitoring of study performance will be an ongoing process and a review has been introduced for all new studies three months after opening.

A more streamlined study approval process has also been introduced with the aim of opening studies within 40 days of the site being selected. This will ensure a robust feasibility process in terms of PI and nurse capacity and capability, as well as that of key study support services (pharmacy, pathology and radiology) to confirm effective delivery of studies to time and target.

In line with the Lord O'Shaunessy report, (Government response to the Lord O'Shaughnessy review into commercial clinical trials in the UK - GOV.UK (www.gov.uk) NIHR are keen to increase commercial activity at all Partner Organisations in the UK. Currently there are two commercially sponsored studies open and recruiting in surgery and Stroke and another due to open imminently in Muscular Skeletal Disease. Positive discussions have been held with commercial organisations to promote WUTH as a site to place studies and expressions of interest have been sent for a dermatology study sponsored by Sanofi and a renal study sponsored by Oxford Population Health.

Moving forward, WUTH have decided to focus on four disease priority areas - Cancer, Respiratory Disease, Stroke and Women's Health – which were chosen in relation to disease prevalence and strong performance. The intention is to develop the portfolio in these specialties particularly with commercial sponsors.

Research team

WUTH has a small research team comprising three adult trained nurses, two paediatric nurses and one midwife (5.8 WTE). They are supported by a research study coordinator and administrator (2.0 WTE). The Trust has also benefitted significantly from nursing and administrative support given by the Agile Delivery Team from The Clinical Research Network, which currently amounts to 4.2 WTE.

The team is managed by a new Research and Innovation Manager who was appointed in November and works on a 0.6 WTE basis. She reports to The Deputy Medical Director and meets with him and the Clinical Lead weekly. They also meet with the Medical Director on a quarterly basis

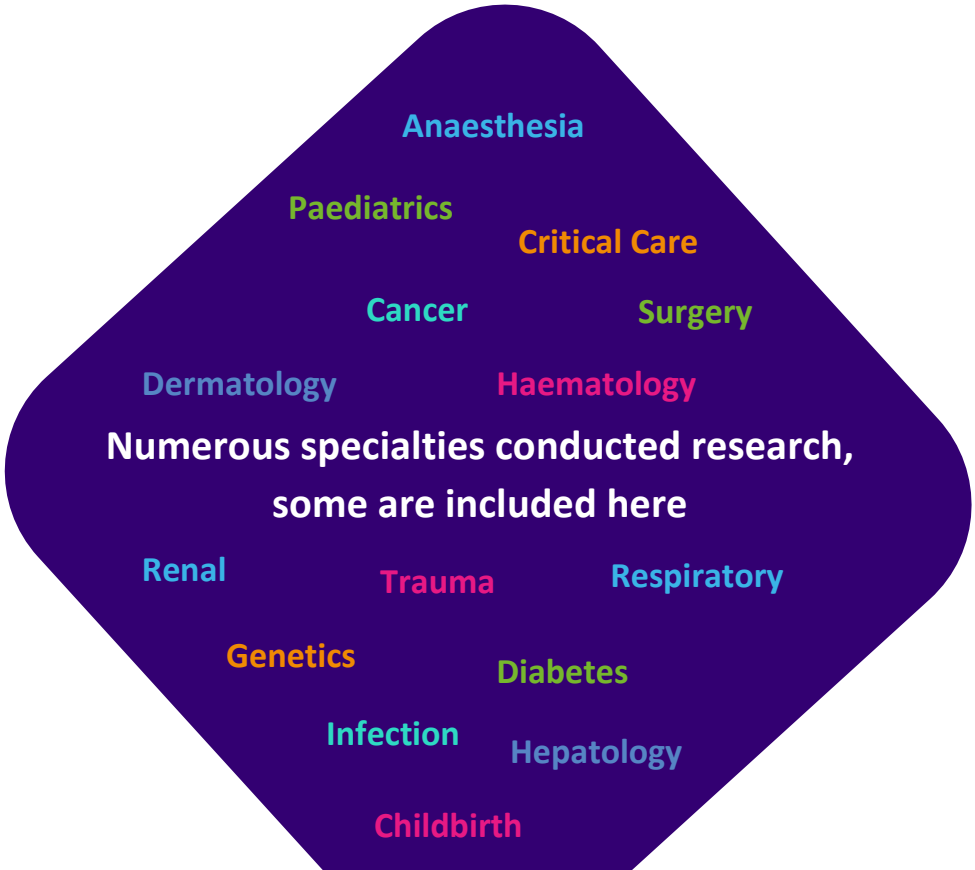
The trust has 43 PI's responsible for studies which are open and recruiting or in follow up.

There are 2 clinicians currently being mentored on the NIHR Associate PI scheme on studies in renal and respiratory disease.

Collaborative working

WUTH are a key partner of the Wirral Research Collaborative (WRC) which was created for Primary-Secondary-Tertiary collaboration going forward. This is still in development, but WUTH are pleased to have agreed to work together with Marine Lake GP practice on a new vaccine study which is due to open in September of this year. The Clinical Lead and R&I Manager attend monthly meetings for the WRC and WUTH have been involved in setting up a meeting for all partners being held in May to bring all partners together to discuss potential plans and ideas for further collaborative working and expansion of the initiative.

Currently, the main focus for WUTH is the refurbishment of the research hub at the Clatterbridge site for which we were successful in securing funding from the CRN:NWC. On completion of the refurbishment, the site will be promoted and advertised to invite commercial and academic collaborations with local partners on The Wirral and beyond.



2.2.4 Commissioning for Quality and Innovations (CQUIN) Indicators

The Commissioning for Quality and Innovation Scheme (CQUIN) is a payment framework that enables commissioners, such as local Integrated Care Boards (ICBs) and NHS England, to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

This framework aims to embed quality with commissioner-provider discussions and create a culture of continuous quality improvement and stretching goals in contracts on an annual basis.

Therefore, the Trust actively linked with NHS Cheshire & Merseyside ICB and NHS England throughout the year with data to support performance and inform of action plans to improve care in specific areas chosen nationally.

NHS England identified a number of clinical priority areas, where improvements were expected during 2023/4. Many of these were short-term clinical improvements that were selected due to their ongoing importance in context of Covid-19 recovery of the NHS.

During 2023/24, the Trust was eligible to participate and report on 10 CQUINs, which are outlined below:

- Staff Flu Vaccinations
- Supporting patients to drink, eat and mobilise after surgery
- Prompt switching of Intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patient meets switch criteria
- Compliance with timed diagnostic pathways for cancer services
- Identification and response to frailty in emergency departments
- Timely communication of changes to medicines to medicines to community pharmacists via the discharge medicines service
- Recording of and appropriate response to NEWS2 score of unplanned critical care
- Radical treatment for patients with Stage I-II Non Small Cell Lung Cancer
- Assessment and documentation of pressure ulcer risk
- Achieving high quality Shared Decision Making (SDM) conversations in specialised pathways to support recovery for Renal and Severe Asthma patients.

For each of these, there was a national target that had to be achieved. The Trust was unable to participate in the 'Compliance with timed diagnostic pathways for cancer' due to the software not being readily available within the Trust and gathering the specific data would require an inefficient manual process. During the year a technological solution has been developed to allow data oversight from April 2024.

The 'Identification and response to frailty in emergency departments' CQUIN 5 commenced this year with initial report demonstrating a position between the target thresholds set nationally. Progress has been steady throughout the year and final achievement has been significantly above the upper target threshold.

The 'Flu vaccinations for frontline healthcare workers' CQUIN 1 has achieved 46% against a target range of 75% to 80%. Whilst this position has not achieved the threshold the Trust has led a significant flu vaccination programme ensuring flu vaccinations are available for all frontline healthcare workers and at easily accessible locations across the Trust.

The Trust has benchmarked in line with local peers. All other CQUINs achieved well above the maximum target range set nationally.

The success of these CQUINs was mainly due to the identification of key leads at the beginning of the year, with regular catch-ups throughout the year to ensure the Trust was on track to make further improvements.

WUTH CQUIN 2023-24 Data Summary

		Target		Year End Performance
No	**Title**	**Minimum**	**Maximum**	**Q4 %**
CQUIN01	Flu vaccinations for frontline healthcare workers	75%	80%	46%
CQUIN02	Supporting patients to drink, eat and mobilise after surgery	70%	80%	97%
CQUIN03	Prompt switching of intravenous to oral antibiotic	60%	40%	9%
CQUIN04	Compliance with timed diagnostic pathways for cancer services	35%	55%	N/A
CQUIN05	Identification and response to frailty in emergency departments	10%	30%	35%
CQUIN06	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	0.5%	1.5%	22%
CQUIN07	Recording of and response to NEWS2 score for unplanned critical care admissions	10%	30%	97%
CQUIN10	Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	80%	85%	87%
CQUIN11	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	65%	75%	93%
CQUIN12	Assessment and documentation of pressure ulcer risk	70%	85%	86%

2.2.5 Registration with the Care Quality Commission (CQC)

The Trust is fully compliant with the registration requirements of the CQC. The Trust reviewed and refreshed its Statement of Purpose during 2021/22 as part of the Trust's CQC registration process. Compliance data with the provisions of the Health & Social Care Act 2008 (Registration Regulations 2010) is co-ordinated by the deputy director of quality governance who oversees compliance by:

- reporting and keeping under review matters highlighted within the CQC Insight Tool and inspections.
- liaising with the CQC and local services to address specific concerns.
- engaging with the CQC on the inspection process, co-ordinating the Trust's response to inspections and recommendations/actions.
- analysing trends from incident reporting, complaints, and patient and staff surveys to detect potential non-compliance or concerns in services.
- reviewing assurances on the effective operation of controls.

Following a comprehensive inspection of services in 2019/20 the Trust demonstrated that progress has been made to achieve better compliance. The Trust remains at 'Requires Improvement' overall but improved in the well-led and safe domains.

There have been further focused inspections including; Urgent and Emergency Care and Medical Services in 2021, Maternity 2023 and Urgent and Emergency Care 2024. Whilst the focused inspections have not changed the overall CQC rating for the Trust, the 2021 inspections have seen an improvement in the rating for Medical Services from Requires Improvement to Good and maintained the position for Urgent and Emergency Care. The 2023 focused maternity inspection maintained a rating of good and the report following the Urgent and Emergency Care focused inspection in 2024 is yet to be finalised.

Safe	Effective	Caring	Responsive	Well-Led	Use of Resources
Require Improvement **2021**	Requires Improvement **2021**	Good **2021**	Requires Improvement **2021**	Requires Improvement **2021**	Requires Improvement **2021**

2.2.6 External Accreditations

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

Current Clinical external accreditation

Accreditation	Area
JAG Accredited	Endoscopy
UKAS A world of confidence	Blood Sciences Microbiology Histopathology
ACSA Anaesthesia Clinical Services Accreditation	Anesthetics
GIRFT GETTING IT RIGHT FIRST TIME	Cheshire & Merseyside Surgical Centre
BSGE	Women and Children's

2.2.7 Freedom to Speak Up

WUTH developed the role of Freedom to Speak up (FTSU) Guardians in 2015, prior to National guidance being issued by Sir Robert Francis. Since then, the Trust has been significantly involved in shaping national policy and guidance around this agenda and has been working hard to improve the speaking up culture within WUTH.

The Trust has increased capacity to support the overall FTSU service, with a new Lead FTSU Guardian and Just Culture Lead becoming embedded in the Trust during 2023/24 following appointment in February 2023.

The trust lead is supported by two existing guardians in the trust along with a network of

26 trained FTSU Champions, whose role is to work within their service areas, promoting and encouraging staff to speak up and signposting to FTSU Guardians where appropriate.

Where a member of staff does not feel able to speak up through the normal management channels, they are encouraged to contact a FTSU Guardian and will also be signposted to relevant support services as necessary.

The profile of the FTSU Guardian in the Trust remains prominent and a variety of Trust wide communication mechanisms are utilised to promote the importance of speaking up and the support available, including leaflets, pull up banners and articles within the Trust's In-Touch magazine. Guardians form part of the staff induction process (including junior doctors) and FTSU training is now required for all staff at a level appropriate for their role, with compliance continuing to increase and subject to standard Trust monitoring processes. Guardians conduct walkabouts within areas to heighten visibility and are linked to departmental cultural reviews as additional support.

Staff can speak up to FTSU Guardians in confidence and make plans together about how best to move forward. Staff can access FTSU Guardians anonymously; although this can prevent effective management of the circumstances (due to insufficient information) and does prevent feedback and support to the individuals concerned. The Trust continues to see low numbers of anonymous concerns raised with only 3 received in 2023/24, which, combined with positive levels of people speaking up, can be a good indication that staff continue to feel confident in approaching FTSU Guardians or local management teams.

FTSU Guardians maintain confidential records relating to information spoken up about and refer concerns to the most appropriate person e.g., Human Resources, management teams or staff side colleagues. Where further investigation is required, this is conducted independently by a senior and suitably trained person from elsewhere in the organisation as required. Progress is fed back to the reporter along with any outcomes or actions taken. FTSU Guardians monitor actions and outcomes and will escalate circumstances if concerns remain unresolved.

The Trust has seen an increase in the number of people speaking up this year with 104 people speaking up in 2023/24 as opposed to 90 people in 2022/23. This increase is seen as positive, and data now falls more in line with regional and national averages.

Our 2023/24 data shows that people accessing the speak up service are across all Divisions and a range of occupational groups.

Policies, procedures, and process is the most reported theme with only 1 concern linked with patient safety, compared to 9 last year. Numbers of staff speaking up regarding patient safety have therefore reduced slightly and although lower than national and regional comparators the figures across the region locally and nationally for patient safety remain low. Effective incident reporting processes continue to capture patient safety concerns and further promotion of the FTSU service and enhanced engagement with clinical staff will be undertaken for 2024/25.

Additional sources of advice and support continue to be available for concerned staff. These include tutors (for students and trainees), Practice Education Facilitators, the Human Resources department, Trade Unions and professional bodies, the Guardian of Safe Working for Junior Doctors, and Staff Support Team. The Trust has also appointed a Pastoral Lead for nursing staff, along with pastoral leads for internationally recruited nurses, clinical support workers and for our staff undertaking widening participation programs e.g., apprenticeships and volunteers. Whilst these services might not necessarily be able to

investigate the concerns themselves, they offer advice, guidance and support and signposting to specialist services as appropriate, including services of the FTSU Guardian team.

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

The Trust also promotes a variety of wellbeing support options including Occupational Health and workforce wellbeing team, Employee Assistance Program and Cheshire and Merseyside resilience Hub and a range of national and local community organisations depending on the individuals' circumstances.

The Trust continues to proactively identify and support staff who share protected characteristics or may be identified as less able / willing to speak up, with excellent links in place with the Trust's Equality, Diversity and Inclusion Lead and a number of WUTH staff network members including LGBTQ+, Multicultural, staff with disabilities and long-term conditions, the menopause network, armed forces network have developed to become FTSU Champions.

Regular reports are produced and submitted to a variety of Trust Management Committees to ensure appropriate monitoring takes place for speaking up data. Potential trends and themes are monitored to ensure that the Trust is capturing and sharing any lessons learned. Data is also submitted quarterly to the National Guardians Office to ensure wider monitoring of speak up process this also includes where staff feel they have suffered detriment as a result of speaking up and data is submitted to the National Guardians Office as required for further monitoring.

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

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

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

WUTH submitted recordings during 2023/24 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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

Admitted Patient Care	Outpatient Care	Emergency care
99.9%	100%	99.6%

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

Admitted Patient Care	Outpatient Care	Emergency care
99.9%	99.9%	99.2%

2.2.9 Information Governance

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

The Trust has completed Phase 1 of the required annual audit of the Data Security and Protection Toolkit (DSPT). This was undertaken by Mersey Internal Audit Agency at the beginning of March. Phase 2 of the audit is scheduled for 24th April. Last year 'Substantial Assurance' was achieved in each of the 13 areas. This resulted in achieving 'Substantial Assurance' overall in the 2022/23 MIAA external audit.

NHSE has changed the submission date for the DSPT each year from March to June so the final submission will be at the end of June 2024. However, the Trust attained 'Standards Met' in the 2022/23 submission in June 2023.

The main focus for the year has been to develop a new training needs analysis as part of the DSPT's updated requirements. This has included a focus on issuing key messages via communications and newsletters and developing a number of specific training PowerPoint modules based on the top incident categories that have been reported over the year. We continue to support the latest processes, technologies and clinical developments by risk assessing and enabling the personal data of patients and staff to be processed in a legal, efficient, and secure way. Our processes are continuously reviewed in line with current good practice, guidance and legislation to ensure the most up to date advice is provided to reduce the information risk across the organisation.

Five data breaches were reported to the Information Commissioner's Office (ICO) by the Trust (see table below) as they met the threshold for reporting. In addition, a data subject contacted the ICO directly regarding a letter that had been incorrectly addressed. The ICO requested a further final letter be sent to the patient outlining all actions already taken by the Trust, with no further action required.

ICO Number	Date	Incident Details
IC-241347-V4V2	June 2023	Staff member accessed another employee's demographics on the electronic record to send a gift to her home. Closed – no further action.
IC-0286-2023	July 2023	Staff member disclosed sensitive information of a patient's electronic record to a family member. Final report submitted to ICO. Awaiting response from ICO.
IC-255615-X5L6	September 2023	Highly sensitive information contained in a summary letter to a GP which should not have been included without the consent of the patient. Status: Closed – no further action.
IC-273876-C8S8	November 2023	Package containing copies of medical records could not be located within Royal Mail under the signed for service. Status: Closed – no further action.
IC-294880-Z8J2	March 2024	Inappropriate access breach by staff member. Staff member accessed records of her ex-partner and family. Status: ICO require an updated summary to be provided after the WUTH investigation has concluded.

2.2.10 Clinical Coding

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

In 2023/24 the Trust continued to commission an external audit programme from the Clinical Coding Academy at Merseyside Internal Audit Agency (MIAA). Two audits have been conducted by MIAA across the year. This provided substantial assurance.

The first of these was an audit of Mortality coding performed in September 2023 with overall accuracy of our coded data reported as:

Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
96.67%	96.28%	100%	96.43%

A second audit was performed on Obstetrics, and Neonates coding in January of 2024. The overall accuracy of our coded data is reported as:

-

Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
93%	87.74%	97.62%	92.54%

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

The Trust will be taking the following actions in 2023/24 to continue to improve data quality:

- Work with colleagues throughout the Trust to improve the quality of our coded data with particular emphasis on clinician engagement and the improvement of documentation around coding for deceased patients.
- Continue to commission external clinical coding audits with expansion of our internal audit programme.
- Ensure the continual development of clinical coding staff, as well as ensuring all staff receive relevant feedback at individual and team level as appropriate.

One member of staff passed the National Clinical Coding Qualification becoming an accredited clinical coder. Three staff will sit this examination in March 2024. The Clinical Coding Trainer was assessed by NHS England and became an Approved Experienced Clinical Coding Trainer allowing us further flexibility with in-house training. This is a key priority to ensure sustainable and resilient service with trained clinical coders being a difficult resource to recruit.

2.2.11 Learning from Deaths

During 2023/24, 1,873 of Wirral University Teaching University patients died during an inpatient episode of care. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

Quarter1	Quarter 2	Quarter 3	Quarter 4
456	411	477	525

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

The MRG discusses findings from these escalated mortality reviews, where key clinicians scrutinise the patient journey, including lessons learnt and whether their deaths could have been prevented. Mortality reviews are also undertaken for all deaths where the patient has a learning disability, autism or a history of serious mental health disorder. Further Quality Assurance mortality reviews are performed on a random sample (approximately 3% of all deaths) . Those reports are shared at the MRG and any concerns are highlighted and considered for further review.

During 2023/24 a total of 164 mortality reviews received further review. This consisted of 60 Primary Mortality Reviews (PMRs), 75 Quality Assurance PMRs,19 Structured Judgement Reviews (SJRs) including 16 LeDeR reviews.

We continue to report all deaths of people who are service users with an established diagnosis of learning disability to NHS England's LeDeR Programme (Learning from lives and deaths – People with a learning disability and autistic people). Wirral University Teaching Hospital reported 16 LeDeR reviews between 1st April 2023 and March 31st 2024.

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

Quarter 1	Quarter 2	Quarter 3	Quarter 4
50	29	34	49

10 of these were still in the process of being completed at the time of writing, due to competing time constraints. In a similar vein, a number of deaths that happened at the close of the previous fiscal year were finished in the first half of 2023/24. The learning summary from the 160 reviews that were finished in 2023/24 is as follows:

Following review, a high percentage (95%) highlighted good or excellent care and treatment. No death was deemed to be avoidable.

The mortality review process allows for escalation to a more in-depth review following discussion at MRG if it is felt a deeper review is required.

Summary of learning, actions the Trust has undertaken and the impact of the relevant actions:

Learning	Actions Implemented
Medication delays and errors	All cases are fed back via the Medications safety Pharmacist (who is a member of MRG) to relevant areas and Medication Safety Optimisation Group (MSOP) committee that has oversight of medication safety across the Trust.
Delays in discharge home (Patients without criteria to reside)	Work ongoing at system level to address delays in discharge
Multiple ward moves	Ward moves audit commenced to learn lessons and look at process around bed allocation
Poor documentation	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads.
Poor documentation around (Mental Capacity Act) MCA and Do Not Attempt CPR (DNACPR) decisions	All these cases are feedback to individual teams and the Trust CPR committee. MCA training and has been refreshed across all areas recently and audits of DNACPR forms strengthened to ensure better compliance.
Communication with families	In cases where there have been lapses in communication, the feedback was taken to clinical teams to reflect and improve.

Specific learning around DNACPR and MCA was noted and communicated formally through the Divisions. A daily DNACPR audit is conducted where any issues highlighted are discussed with the medical team via the Resuscitation Services Lead.

Another prominent theme is documentation issues, this is a theme noted through other avenues and not just mortality reviews. The main themes from these findings related to issues with updating or completing core documentation, progress notes, care planning, and recording of decision making. There were nine findings relating to record keeping overall that were deemed to be significant but not causative.

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

2.3 Reporting against Core Indicators

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

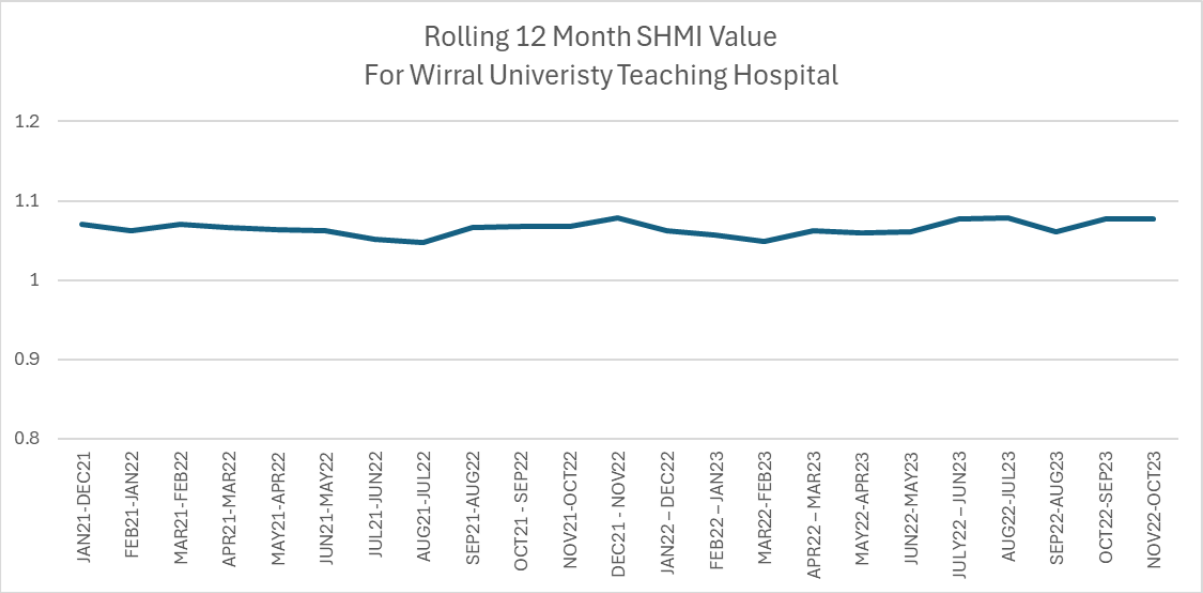
The SHMI is the ratio between the actual number of patients who die following hospitalisation at WUTH and the number expected to die on the basis of average England figures taking into account the patient cohort and acuity of WUTH. SHMI gives an indication for each non-specialist acute NHS Trust in England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

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

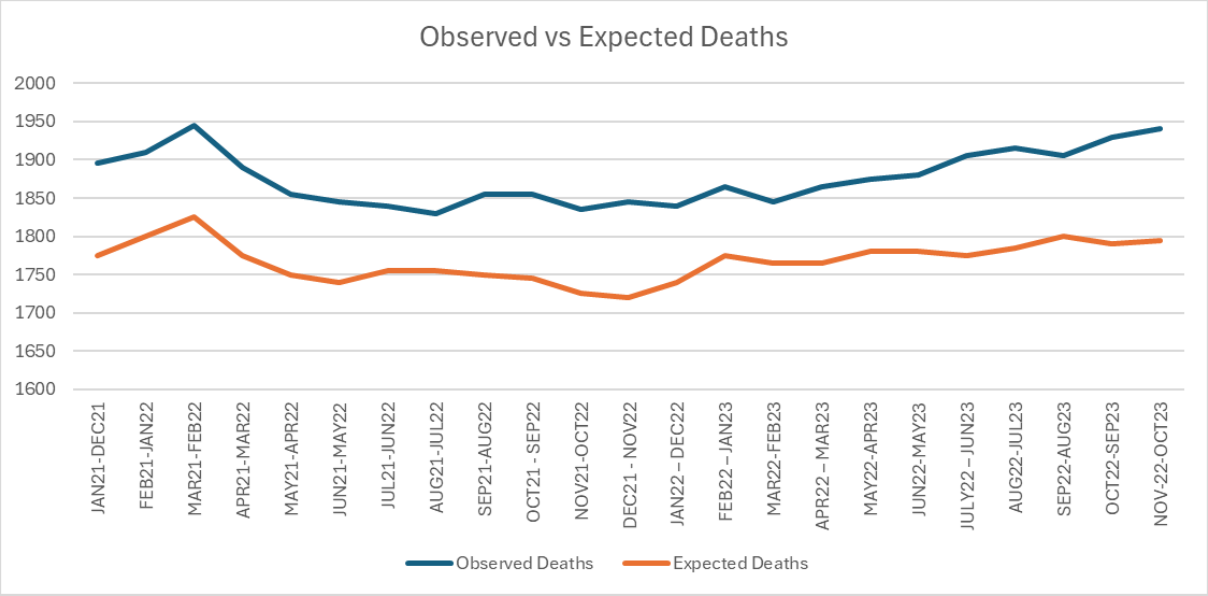
The last year's most up to date data (published 11th April 2024) is in the table below. Due to time lapses in the data processing there is a 4-5 month deficit.

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

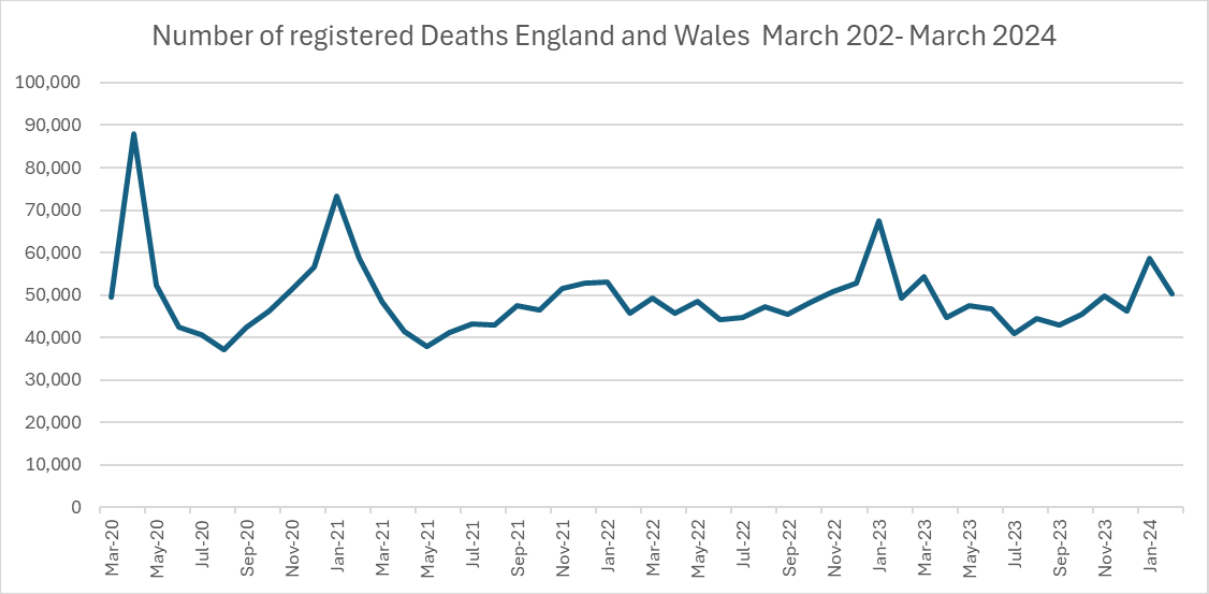
The graph below shows the SHMI 'as expected' for WUTH for the past 3 years.



When we examine the observed and expected death over the last 3-year period, we see that despite fluctuations the observed deaths are consistently higher than the expected deaths for the Trust. However, this is still within the 'as expected' range. The rise in observed mortality is consistent with our experience of an aging, multi-morbid population.



The National picture shows relatively stable mortality coming out of the pandemic, spiking in the Winter months as expected due to rises in respiratory deaths and flu.



Source of data Deaths registered monthly in England and Wales – Office for National Statistics (ons.gov.uk)

2.3.2 Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMS) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering two clinical procedures, hip replacements and knee replacements, PROMs calculate health gains are surgical treatment using pre and post-operative survey. This data has been collected by all providers of NHS funded care sine April 2009.

The latest finalised PROM's for the year 21-22 were released in July 2023.Results for the previous year were unavailable due to the Covid pandemic pre-operative Questionnaire 1 and post-operative Questionnaire 2 rates being too low for analysis. This was a recurrent theme during the pandemic due to less activity and fewer face-to-face appointments to ensure enrolment and understanding in the process.

The hip and knee replacement patients are encouraged to enrol and submit the pre-operative questionnaire that includes 2 general health metrics and one joint-specific metric (i.e. EQ-VAS, EQ 5D and Oxford hip/knee score).

For Hip Replacement Surgery we had 111 patients return in both Q1 and Q2. Improvements were noted in the 2 general health metrics and the Oxford Hip Score, these improvements are within the expected findings.

For Knee Replacement Surgery we had 92 patients return in both Q1 and Q2. Improvement were noted in the 2 general health metrics and the Oxford Knee Score, these improvements are within the expected findings

All things considered, the improvements are within typical limits. Since this is a health improvement measure rather than a genuine outcome measure, we seek to be within the normal range rather than

outlier status as we don't want to wait until a patient deteriorates before giving surgery to maximise the health gain. In order to improve Q1 compliance and clarify the necessity of completing the Q2 questionnaire, we have standardised our "Joint School" procedure. We anticipate representative findings with a higher return rate and will continue to monitor outcomes.

Total Hip Replacement 2021-2022 Data published July 2023		
EQ VAS	**EQ-5D Index**	**Oxford Hip Score**
15.676 Not an outlier	0.424 Not an outlier	21.291 Not an outlier

Total Knee Replacement 2021-2022 Data published July 2023		
EQ VAS	**EQ-5D Index**	**Oxford Hip Score**
6.503 Not an outlier	0.328 Not an outlier	18.865 Not an outlier

1.3.3 The Percentage of Patients Readmitted to Hospital Within 28 Days

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

Wirral University Teaching Hospital monitors readmissions rates monthly by the Trust Board. Readmission rates are calculated nationally by NHS England and giving a banding. Please see table below for banding details.

Band	National Average
B1	Significantly lower than the national average at the 99.8% level
B5	Significantly lower than the national average at the 95% level but not at the 99.8% level
W	National average lies within expected variation (95% confidence interval)
A5	Significantly higher than the national average at the 95% level but not at the 99.8% level
A1	Significantly higher than the national average at the 99.8% level

Age Range	2021/22 (Banding)	2022/23 (Banding)
<16	18.4 (A1)	19.0 (A1)
16+	13.3 (B1)	12.0 (B1)

The readmission rate for <16-year-old has slightly deteriorated when looking at the year-on-year comparison whereas the readmission rate for 16+ has improved. The banding for each indicator value had remained consistent with WUTH being Significantly higher than the national average for <16 and significantly lower than the national average for 16+.

Regular review and analysis of readmission data, including detailed assessments of the reasons behind each readmission can identify areas for improvement in care delivery processes. Implementing targeted interventions based on these findings can help mitigate avoidable readmissions over time.

WUTH continually takes the following actions to improve this indicator and the quality of its services by:

- Working to improve discharge information as a patient experience priority.
- Reviewing and improving the effectiveness of discharge planning
- The Trust monitors readmission information and takes action as required.

1.3.4 Ensuring People have a Positive Experience of Care

The Trusts responsiveness to Personal Needs of its Patients

Patient experience is measured by scoring the results of a selection of questions from the National Inpatient Survey, focussing on the responsiveness to personal needs. Feedback indicated that personalisation and service responsiveness are important issues for inpatients.

Reported performance for 2020/21 data, which is the latest published data from March 2022 is 75.1%

The data is produced by the Care Quality Commission (CQC) Inpatient Survey which is an official statistic and deemed to be of good quality. This indicator is also assured by the Indicator and Methodology Assurance Service (IMAS). This is a service provided for health and social care, which assesses factors such as the statistical methodology, the purposes of the indicator and the quality and suitability of the data source for the purpose of a given indicator.

WUTH were banded as "Better" for one question which related to the provision of information provided when leaving hospital, all other questions were banded as about the same. Regionally WUTH were also identified as being in the top five regional hospitals in relation to the section on being asked to provide Feedback on the Quality of Care, however WUTH were identified as in the lowest performing hospitals regionally for the section in relation to Admission to Hospital. Patient flow is a key priority objective for WUTH, however it is also acknowledged that those regional organisations identified as the top performing hospitals for this section are specialist organisations focusing on cancer services and cardiology.

Staff Recommend the Trust as a Provider of Care to Their Family and Friends

The NHS Staff survey is conducted annually. In 2023 Wirral University Teaching Hospital submitted 2461 responses which equates to a 38% response rate.

From 2021/22, the survey questions moved to align to the seven elements of the NHS 'People Promise' and retained the two previous themes of engagement and morale. These replaced the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

Scores for each indicator of the People Promise Element – We are compassionate and inclusive can be found below.

Indicator from 'We are Compassionate and Inclusive'	2022/23	2023/24	Benchmark
I feel my role makes a difference to patient/service users	87.33	86.49	Below national average
Care of patients / service users is my organisation's top priority.	69.71	69.09	Below national average
My organisation acts on concerns raised by patients / service users.	66.11	65.19	Below national average
I would recommend my Organisation as a place to work	55.31	56.26	Below national average
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	62.09	64.63	Below national average

Wirral University Teaching Hospital is below the national average in the above 5 indicators. To improve the percentage score and the quality of service the Trust will continue to hold Leaders in Touch meeting, conduct the quarterly pulse survey and maintain staff networks that have been established to ensure staff have the opportunity to gain access to results and contribute their ideas and shape plans.

1.3.5 Venous Thromboembolism (VTE)

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

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

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

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

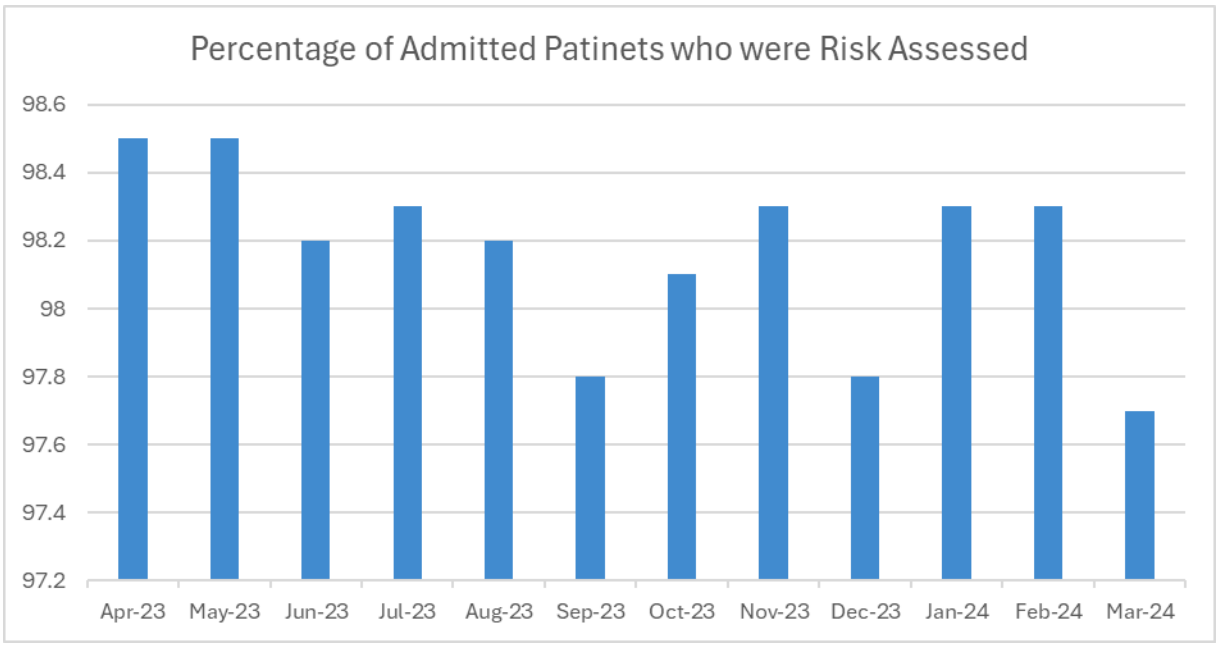
- Initial VTE assessment should be completed with 12 hours of admission,
- Consultant VTE assessment should be completed within 27 hours of admission

- VTE assessment should be reassessed with a change in clinical condition.

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

The Trust aims to reach a standard of 95% of patients have an initial assessment (or consultants' assessment if this is first assessment completed) within 12 hours of admission. Furthermore, the standard for a consultant VTE assessments being completed within 27 hours is 95%.

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



Data for March is currently undergoing assurance checks to confirm data accuracy and therefore the figures for March 2024 are likely to be changed.

Although not explicated stated in our policy, we would expect all patients to have a VTE assessment during their hospital admission is 95%.

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

Both VTE assessment and HAT data is presented quarterly to the trust's Clinical Outcomes Group.

The latest HAT data report covering January to June 2023 which covers part of the reporting period of this report has shown a HAT rate of 35%. There is no national data to make a comparison however this is reported as 50-60% by Thrombosis UK.

Of the 35% deemed to be HAT, none of the cases were felt to be preventable.

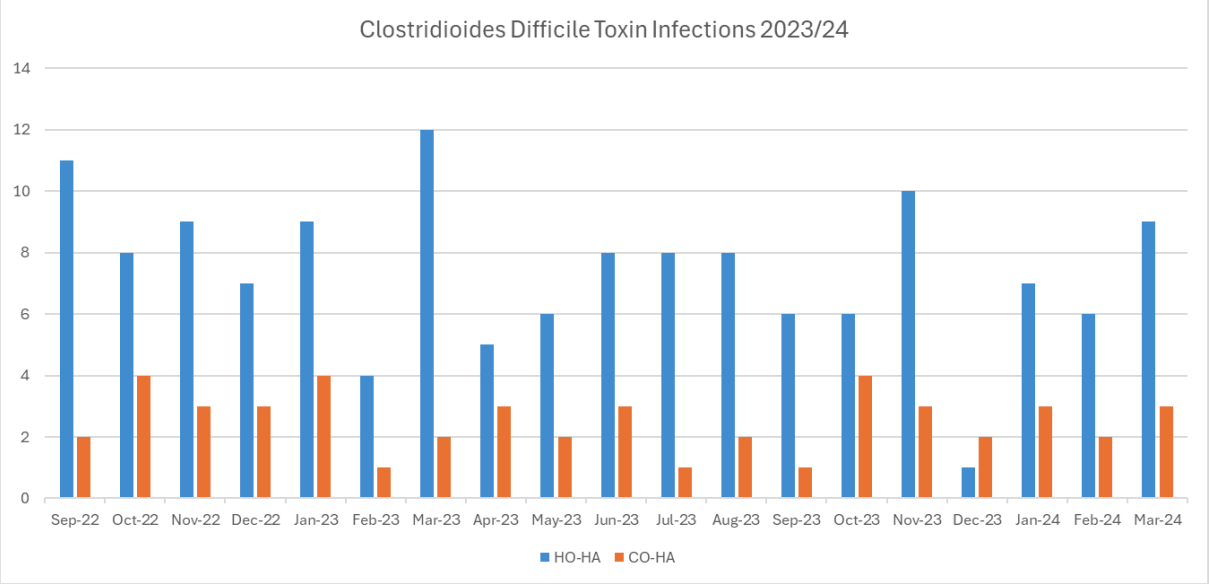
2.3.6 Clostridium Difficile Infections

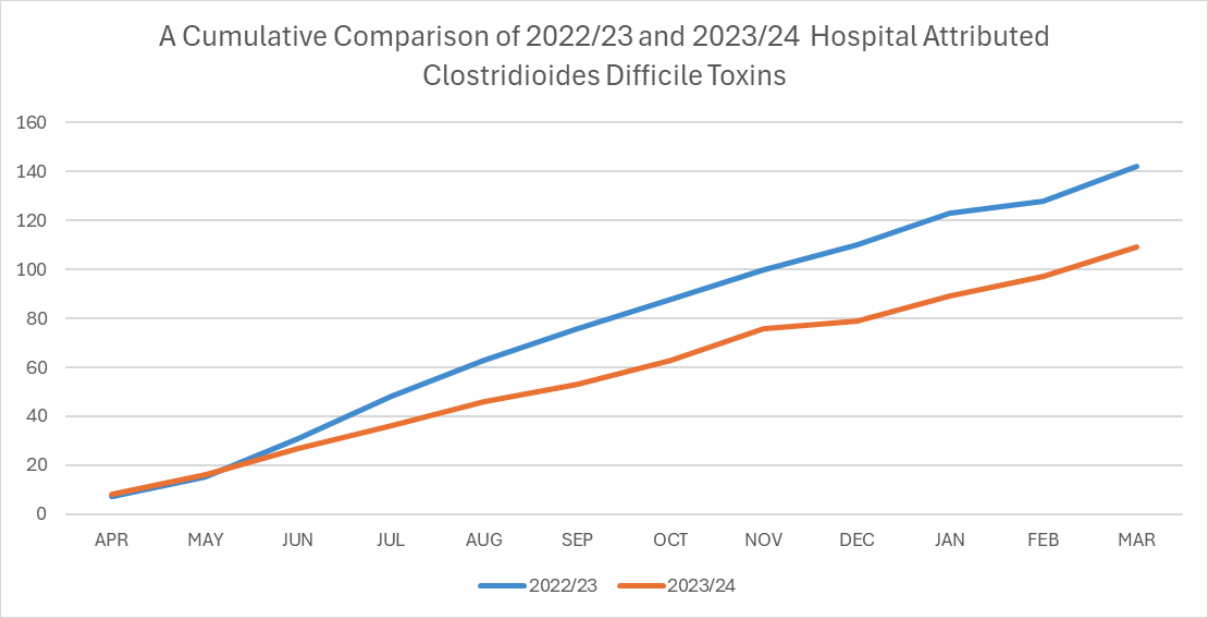
Clostridioides difficile is recognised as a significant healthcare associated infection and multiple infection control measures and treatment modalities have been looked at and this continues to be an evolving field.
Recent guidelines suggest that the management of severe CDI should be considered a medical emergency and that patients diagnosed with CDI need to be urgently assessed and then reviewed regularly, preferably by a multidisciplinary team, to ensure that patients receive prompt and optimised care.

The 2023/24 NHS Standard Contract includes quality requirements for NHS trusts to minimise rates of *Clostridioides difficile* (*C. difficile*) infections to threshold levels set by NHS England. The thresholds for each trust, together with the methodology used to identify these, are set out in the NHS standard contract, Publication reference PR00150. The threshold for WUTH in 2023/24 was set at 71.

Since April 2017, reporting trusts have been asked to provide information on whether patients with *C. difficile* had been admitted to the reporting trust within the three months prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases.

For 2023/24, as for 2021/22 and 2022/23, trust level thresholds comprise total -healthcare-associated cases (i.e., HOHA and COHA).





How was this achieved?

WUTH continue to work hard to reduce the number of patients identified with CDT by focusing on interventions as outlined below:

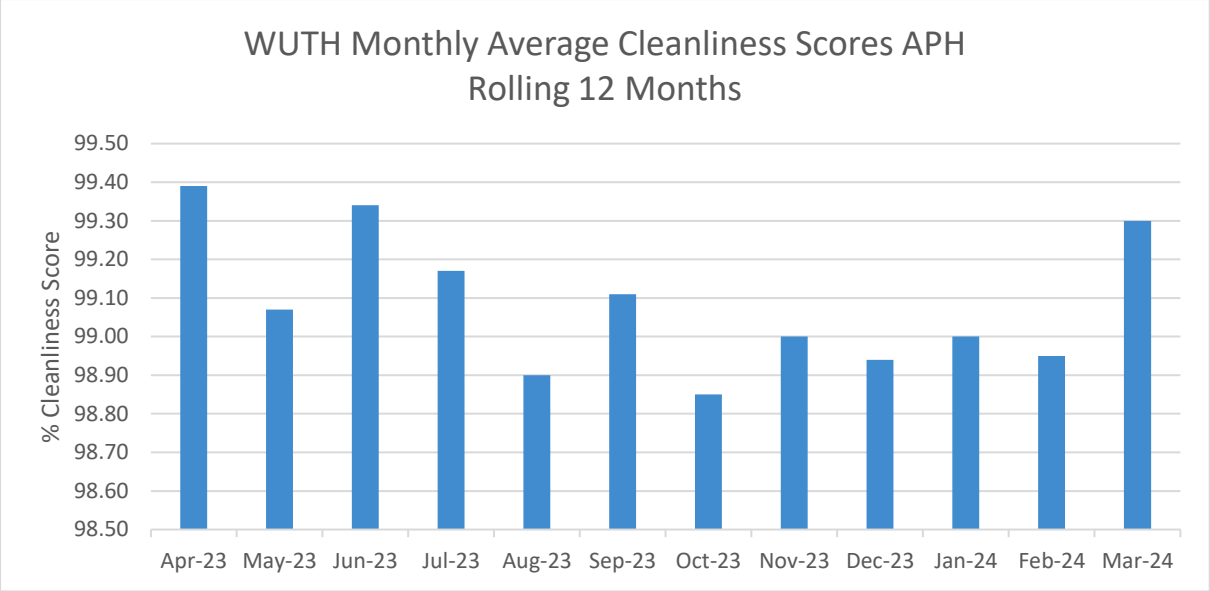
Reactive and proactive decant – patients are moved to a designated area whilst their immediate environment undergoes Hydrogen peroxide vapour (HPV)treatment, this promotes a clean safe environment for all patients and reduces the risk of cross infection.

Development of an IPC Communication strategy - The proposal was to develop a plan of action with the overall aim of increasing awareness regarding CDT in the organisation using lots of different techniques. Resources and training aids were developed to identify the different roles and responsibilities for all staff groups. Key stakeholder engagement was sought from utilising lots of different forums using different motivational materials. The underpinning project of the strategy was the launch of a five-month campaign focusing on 5 key priorities, Cleaning, Isolation, Sampling, Hand Hygiene, and the Environment. The campaign became part of the wider acclaimed 'Keep it Simple' campaign but gave particular focus on C.diff under the branding tag line '*It's not difficile*'.

PSIRF – from RCA to REC - Rapid evaluations of care replaced the traditional Root cause analysis in November 2023 and common themes identified included the use of Broad-spectrum antimicrobials, overlap of care with another patient diagnosed with CDT, limited assurance around domestic cleaning and missed opportunities to obtain a sample from the patient.

Cleanliness

The new 'National Standards of Healthcare Cleanliness 2021' have been introduced within the Trust. The standards include monthly mandatory efficacy audits. Representation is required from all cleanliness responsibility groups of Facilities, Nursing, Estates, and IPC. There are 98 patient-facing areas identified across the Trust that require an efficacy audit to be conducted annually. The functional areas are randomly selected each month. The results of the new mandatory efficacy audits are reported monthly to IPCG and represented as a percentage score, along with the key trends identified, see table below.



Monitoring and assurance

The Trust has not been set a national tolerance for *Clostridioides difficile* however local tolerances have been discussed with ICB and a stretch target of less than 9 cases per calendar month has been agreed.

This will be monitored through reports to the Trust governance structure detailing infection rates for Clostridium Difficile Infections alongside other Healthcare Acquired infections including MRSA Blood-stream infections, Klebsiella, Pseudomonas and E. Coli bacteraemia's and Nosocomial Covid-19 infections.

The reporting will also detail learning from reviews of these infections and the quality improvement progress.

Antimicrobial stewardship continues to be a key factor in prevention of avoidable Clostridium Difficile Infections and will be reported through the Trust governance structure and with ICB oversight.

The Trust has implemented the National Infection Prevention and Control Manual and will monitor compliance with this.

2.3.7 Patient Safety Incidents

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

During this reporting period the design and frequency of NRLS reports has changed from bi-annual to annual in preparation for the launch of Learning from Patient Safety Events (LFPSE). The Trust changed the way it reports incidents into a national system that impacts on patients in September 2023. This now allows organisations to assess its incident data by physical and psychological harm to each

patient, rather than just a previous level of harm for the incident.

Degree of Harm in Incident Reports

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

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

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

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

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

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

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

The data below is the latest published date for 2020/21. In this reporting period the Trust only reporting into the NRLS. This data has been validated by the NRLS and each patient safety incident is reviewed for accuracy prior to uploading.

Period	Number of Incidents Uploaded to NRLS from WUTH	Number of Incidents with Degree of Harm Severe or Death	% of patient safety incidents that resulted in Severe Harm or Death
2020/21	13,245	31	0.23
2019/20	6,096	9	0.14
2018/19	6,362	16	0.25

From 1st April 2022 to 31st March 2024 , WUTH declared a total of 13 Serious Incidents declared during the first half of the year under the Serious Incident Framework and 3 Patient Safety Incident Investigations initiated during the second half of the year, under the Patient Safety Incident Response Framework (PSIRF).

Of the 16 Incidents 2 were deemed to be a Never Events.

The Trust has fully embedded both PSIRF and the Learning From Patient Safety Event (LFPSE) system during the year, with a greater focus on learning, alignment to quality improvement and patient engagement. There is now a focus on embedding revised pathways in practice moving forward.

Part 3

3.1 Overview of the Quality of Care and Performance

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

3.1.1 Staff survey

The NHS Staff Survey, undertaken by independent external organisation, Picker Europe, took place between September and November 2023. The Trust applied a mixed mode of paper based and electronic (via email) surveys in order to maximise access and completion of survey, with an increased number of paper copies made available this year, for our Estates and Facilities teams and to support access for our Clinical Support Workers in Continuing Care.

We had a 38% response rate this year, with 2,461 staff completing the survey. This is however significantly lower than last year (48%) and below the Acute and Community & Acute sector average of 45%.

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

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

People Promise Elements	Trust 2023 Score	National 2023 Comparator Average	Statistically significant Change from 2022?
We are compassionate and inclusive	7.18	7.24	No
We are recognised and rewarded	5.73	5.94	No
We each have a voice that counts	6.51	6.70	No
We are safe and healthy	6.01	6.06	Significantly higher
We are always learning	5.32	5.61	No
We work flexibly	6.0	6.20	Significantly higher
We are a team	6.56	6.75	No

Below, are the scores for the two themes outside of the NHS People Promise that remain a key benchmark for the National NHS Survey, 'Engagement' and 'Morale'.

Theme	Trust 2023 Score	National 2023 Comparator Average	Statistically significant Change from 2022?
Engagement	6.67	6.91	No
Morale	5.70	5.91	No

The Trust scores slightly below average in all areas, with no statistically significantly change, except for We work flexibly, where there is a significantly higher statistical change from last year.

Feedback from staff this year highlights that more staff would recommend the organisation as a place to work and receive treatment.

Feedback also highlights that staff feel:

- there is more compassion being displayed at WUTH with more compassionate leadership.
- greater satisfaction with the level of pay and feel more recognised by the organisation.
- more able to make improvements happen in their area of work.
- less burned out and that improvements have been made to reduce work pressures and stressors.
- they have more opportunities to work flexibly and that WUTH is committed to flexible working.
- the new appraisal and check-in process enables a better, quality conversation.
- that line managers are more supportive; caring about your wellbeing and are addressing concerns.

Areas of focus for the forthcoming year are:

- a commitment to making our workplace more equal, diverse and inclusive and asking all staff members to actively support and contribute to these efforts.
- a focus on race equality, with actions taken to ensure WUTH is pro-actively anti-racist
- launch of a new Trust monthly recognition scheme – CEO Star Award and Employee / Team of the month for patient care and support services.
- Continued implementation of the new flexible working policy and arrangements, targeting areas of lower flexible working arrangements.
- Invest in physical intervention training and support for staff.

The 2023 staff survey results will be used as one of a number of engagement diagnostics that enable '*staff voice'* to be heard and acted upon. The results of this year's survey will be used to shape the priorities for 2024/25 Trust wide plans including People Strategy delivery plan. Further to this, survey results will also inform 2024/25 divisional delivery plans.

A programme of cascade is being implemented throughout March and April, with Divisional events scheduled to feedback results to staff and provide an engagement

opportunity to work together with staff on identifying key areas of priority and actions needed to support improvements.

3.1.2 Occupational Health & Workforce Wellbeing

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

Improvements and key activities achieved this year includes:

- Improved Occupational Health referral to treatment times and health report turnaround times .
- Increased psychotherapy capacity has been established to support staff.
- Collaborative and holistic wellbeing approach taken, with wellbeing and professional nurse advocates to ensure provisions are in line with the needs of our workforce.
- Mental health first aid training.
- A range of social networking opportunities now available, including our disability, multicultural and LGBT+ staff networks and book club. A Menopause staff network, and leadership and management networking opportunities linked with our leadership masterclasses have embedded.
- Wellbeing conversation now embedded as 'check ins'.
- Quarterly "Wellbeing surgeries" which focus on a key topic, last surgery focused on men's mental health. Links have been established with internal and external stakeholders to offer a range of support options focussed on the themes identified such as mental wellbeing and long term conditions.
- Staff Wellbeing areas across both sites with good usage.
- Occupational Health and Wellbeing staff deliver sessions that are integrated within Managers essentials training, induction and Wirral Enhanced Preceptorship Programme (WEPP).
- A number of 'morale boosters' provided to staff including thank you breakfasts, staff awards, Christmas door competitions, gingerbread competitions, CSW / Nurses / HR Day all celebrated.
- Assessment of staff's measles immunity status undertaken and MMR boosters offered as required.
- Psychoeducation session facilitated by OH Psychotherapist on Enhance Emotional Resilience & Staying Healthy and additional bespoke workshops on staff identified issues such as Low Mood, Social Anxiety, Post Traumatic Stress Disorder, Health Anxiety etc.
- Relaunch of Trust's Employee Assistance Programme (EAP) resulting in increased up take by 20%
- Health Surveillance policy and programme reviewed and re-launched.
- Launched the new EAP application Wisdom for all staff.
- Achieved SEQOHS annual re-accreditation.
- Wellbeing walks during ongoing industrial action by service leads and professional nurse advocates (PNAs).
- EAP counsellor deployed onsite during ongoing industrial action to proactively support staff.
- Extra counsellor sessions via Red Poppy to support staff where required.

- Responsive Mental health support post adverse events / incidents in and outside of the workplace.
- Listening events within Divisions to understand individual service mental health needs and address these.
- Timely supervision and de-brief events held within clinical areas to support staff and help restore wellbeing following trauma.
- Freedom To Speak Up Leads undertake bi-weekly walk abouts.
- Menopause fast track clinic with access following triage to Consultant Gynaecologist.

Areas of focus for the forthcoming year:

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

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

An annual delivery plan is produced for each year of the People Strategy, and it is anticipated that activities within the 2024/25 delivery plan relating to Occupational Health and Wellbeing will include:

- Grow OH strategy tracked, and key achievements recognised.
- Collaboration with Clatterbridge Cancer Centre to offer cross Trust wellbeing events.
- Occupational Health Nurse led drop-in sessions.
- Wellbeing walks around both sites led by trained walkers.
- Kindness and Civility co-creation group to continue to grow and deliver kindness initiatives such as nominate a 'good egg campaign' and second year of the Gingerbread Team Building competition.
- Quarterly Wellbeing surgeries to have a focus on both physical and mental wellbeing.
- Health Kiosks to return to continue to promote self-awareness and personal health responsibilities.
- Suicide and Domestic Abuse policy to be developed.
- Online wellbeing session to be run by Talking Together Wirral with regular on-site presence.
- Further psychoeducation session – topics identified by staff such as Low Mood, Social Anxiety, Post Traumatic Stress Disorder.

3.2 Cheshire and Merseyside Surgical Hub

Background

The development of the Cheshire & Merseyside Surgical Centre at Clatterbridge was in response to the national impact on elective waiting times resulting from the COVID-19 pandemic. In 2021, NHS

England requested applications from Trusts, against the Targeted Investment Fund (TIF), who were keen to develop regional elective centres.

Wirral University Teaching Hospital (WUTH) has two main sites, the acute site at Arrowe Park (APH) and the planned elective site at Clatterbridge (CGH). As part of the Trust strategic vision to develop the CGH site, plans were in place to develop up to 6 further theatres to maximise the elective bed base and provide growth for current and new services.

An initial application was made to TIF for two additional multi-specialty laminar flow theatres and a new Phase 1 recovery, this was successful, and the Trust was awarded £10.6m. Construction work started in October 21 and was completed in November 22, 13 months.

During the construction of the first phase of the development a further sum of funding was nationally made available. A second successful application was made, securing a further £14.95m, for a further 2 multi-specialty laminar flow theatres, minor operations room, expanded phase 1 recovery, new admissions area, and a remodelling of the phase 2 recovery, in addition improved staff facilities and dedicated perioperative education facility. The second phase started in November 22 and was completed in October 23, 11 months.

Along with the estate development, this programme has developed clinical pathways which has led to the Cheshire & Merseyside Surgical Centre (C&MSC) regional facility of the becoming a GIRFT Accredited site and expanding its collaborative working with the Countess of Chester (CoCH), specifically with Orthopaedics. It was the collaboration with CoCH which led to the team being shortlisted for a HSJ award in November last year.

Since the opening of phase 1 in November 22, the service has operated on 5,000 more patients from Wirral and the wider region, than would have been possible without it.

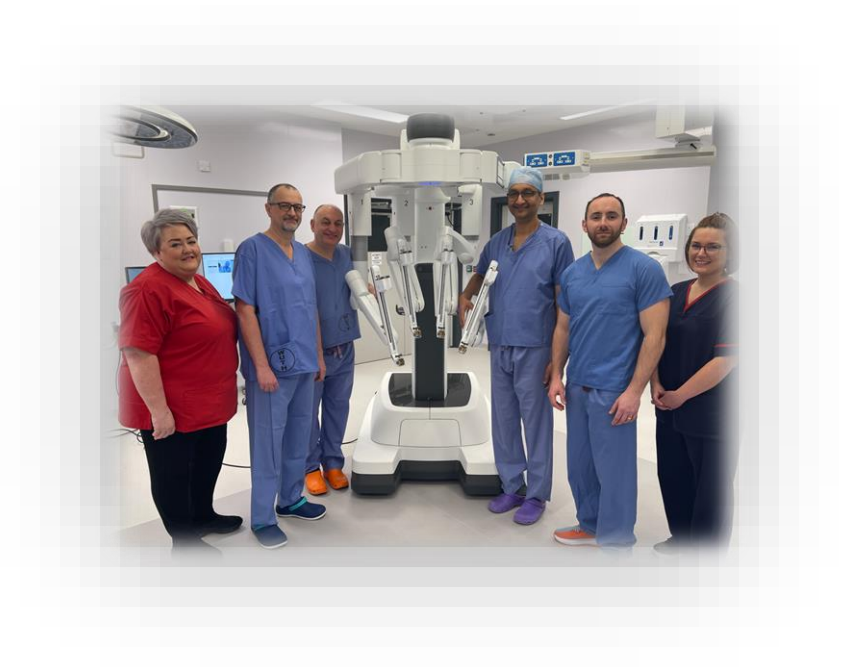
Developments

The development of the C&M Surgical Centre at Clatterbridge is more than extra operating capacity for the region. It's been an opportunity to revisit clinical pathways, learning from best practice in the region and by GIRFT expectations, to improve what we had and to optimise our services.

We started with developing our High Volume Low Complexity (HVLC) lists in one specialty. In doing so we became a regional lead in HVLC and have been asked to present a national forums in the north of England. We have taken our own learning and shared this across other specialties. As a result of HVLC operating lists, we have seen our arthroplasty lists increase from three patients per list to four. In general surgery, our hernia lists increase from five to eight and in Urology our flexicystocopy lists increase from sixteen to twenty-four. In turn, increasing the throughput without compromising clinical quality and care, shortening the waiting lists which now are amongst the lowest in the region.

Following our GIRFT Accreditation visit and through the Further Faster programme, we have been encouraged to develop our Right Procedure Right Place workstream. We have focused on hand surgery which has led to a re-engineering of the patient pathway, again increasing the throughput of patients per list and improving the patient journey as they spend no more than 2 hours in the hospital setting opposed most of the day previously. The other advantage has been seen in the freeing up of operating room and due to the procedures taking place in a minor operating room it has altered the staffing model, freeing up a trained staff member to support the delivery of another operating list.

During 2023, the service secured £2.2m from the Cancer Alliance to purchase a robot for the Clatterbridge site. This has doubled the Trusts robotic capacity and has expanded the procedure range at Clatterbridge. The has had the added benefit of further boosting the morale of the team at Clatterbridge and the recruitment of new staff who see the development and the opportunities it offers.



To support the expanded procedure range and to increase the case complexity at Clatterbridge and release the demand on APH inpatient beds, the service will be opening an Enhanced Recovery Unit in the 24/25 financial year. The facility will be governed by Perioperative Medicine and has led to a review of clinical pathways to support a higher acuity patient cohort at Clatterbridge. In parallel to this, the new Community Diagnostics Centre (CDC) will open in April and places Clatterbridge as only one of eight "cold" elective sites in the country to have an integrated Surgical Centre and CDC. The benefit this brings to patients and clinical staff is the ability to carry out intra and post operative imaging, which reduces the need to transfer patients to APH.

Challenges

The development of the C&M Surgical Centre at Clatterbridge has not been without its challenges both operationally and clinically.

The delivery of mutual aid has been challenged for a number of reasons covered in this section, which have mostly been overcome through the close collaboration with the Countess of Chester and the involvement of our Clinical, Operational and Corporate teams from both Trusts.

The most significant challenge has been the digital developments to transfer patient information between Trusts using the C&MSC. For patient pathways to be as smooth as possible without duplication of attendances, and therefore NHS resource, between a patients local trust and Clatterbridge, an integrated patient access system is required. As Clatterbridge is a regional asset, patients can come from across Cheshire & Merseyside, and therefore patient information is not readily available at Clatterbridge via WUTH Cerner PAS. Ideally, patient information would be a seamless, automated process, but due to the pace of the development and the technical resource needed to establish this, an interim solution was developed using a secure cloud service called Egress. While this enables the safe transfer of patient information into the WUTH Cerner PAS it is not seamless and does rely on a significant amount of admin time.

The C&MSC has not seen its maximum utilisation of the facility due to only one Trust using the facility with any regularity. Several engagement presentations and visits over the last 18 months and executive discussions have taken place, with the main reason for not using the C&MSC seems to be financial concerns by the patients local Trust. Regional leads and Directors of Finance are working through financial models to ensure patient care is delivered timely.

At the start of the development several expected and unexpected clinical challenges presented during pilot operating lists, due to existing procurement contracts and clinical preferences. Challenges around orthopaedic implants and anticoagulation pathways were the most challenging though solutions have been found which has enabled the scaling up of the arthroplasty lists and the wider offering to the region.

Communications & Feedback

Throughout the development of the C&MSC the programme has had a dedicated workstream for stakeholder communications. This workstream covered several facets from staff and patient experience during the construction and post go live period, which led to several operational and clinical changes to improve the experience, ensuring the highest standards are achieved.

It also covered external aspects from visiting surgeons, public and media interest. A dedicated C&MSC webpage has been developed as a repository of information on the C&MSC along with copies of the external communications and press releases.

The communications have been seen as a success with visits from dignitaries, other surgical hub development teams and regional clinical leads speaking highly of the facilities and the team.

3.3 National Safety Standards for Invasive Procedures (NatSSIPs) 2

Safety around invasive procedures has been a focus within the Trust and significant improvement has been seen. The launch of NatSSIPs 2 has provided an opportunity to review our progress to date and consider further actions to strengthen safety for invasive procedures. The Trust has progressed guidance in relation to local safety standards and these standards have been approved for use.

The development of Local Safety Standards now allows improvement in oversight and regular audits of compliance. Progress with oversight will continue to be monitored via the Clinical Outcomes Group as a key element in the Trust most recent Never Event report.

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

Gaps within placement rotations for doctors in training, alongside vacancies in other staff groups and intensifying workload are challenging not only for WUTH but across the NHS. Rota gaps are influenced by a range of factors involving several different external stakeholder organisations (e.g. specialty training and foundation training programmes, lead employer NHS trust). Internally within WUTH, several departments including medical staffing, medical education & Guardian of Safe Working are involved in monitoring and addressing the impact on both educational and service delivery resulting from rota gaps. Data from the GMC training survey, local surveys and feedback via the Junior Doctors Forum helps triangulate the impact of rota gaps. The recruitment of locally employed Trust grade doctors and other experienced clinicians assists reduction of impact resulting from gaps within doctors in training rotations. Where this is not possible, the Trust has signed up to the North West Collaborative bank to ensure appropriately experienced doctors with the right skills are able to take up shifts created by rota gaps. Further collaboration between relevant stakeholder groups to identify further mechanisms for improvement is on-going.

3.5 Trust Performance Indicators

The indicators in this section have been identified by the Trust Board in consultation with stakeholders or are a national requirement and are monitored throughout the year indicated in table below:

Quality Account 2023/2024– Performance Metrics		
Performance Indicators	**Target**	**Full year**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	80%	58.19%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (Arrowe Park site)	95%	62.01%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (WUTH ED only)	95%	48.34%
C. difficile: variance from plan	71	109

Maximum 6-week wait for diagnostic procedures	99%	97.70%
Venous thromboembolism (VTE) risk assessment	95%	98.2%

Due to changes in standards against our Cancer targets mid-year we are unable to correlate annual data. Below is the data for each quarter. Quarter one and quarter 2 data is comparative as is quarter 3 and quarter 4. Targets were combined in October meaning the first half of the year cannot be compared to the second half of the year.

The below table shows the target and the achieved percentage for the first half of the year.

Performance Indicators	Q1		Q2	
	Target	Achieved	Target	Achieved
62 day wait for urgent GP referral to definitive treatment	85%	71.66%	85%	73.61%
62 day wait for NHS screening referral to first definitive treatment	90%	80.43%	90%	91.38%
62 day wait for consultant upgrade to first definitive treatment	85%	77.42%	85%	96.77%

The below tables shows the target and the achieved percentage for the second half of the year

Performance Indicators	Q3		Q3	
	Target	Full Year	Target	Full Year
62 day wait for urgent GP referral, NHS screening referral or consultant upgrade to first definitive treatment	85%	71.79%	85%	73.68%

However it should be noted that for 2023/24 the NHSE requirement was the Trust position by the end of quarter 4 was that the combined 62 day target should be >= 70% as acknowledgement of recovery post pandemic with a view to moving into 2024/25, increasing the performance for the 62 day combined wait. The Trust achieved that early in quarter 3 and improved in quarter 4. Whilst quarter 3 and quarter 4 don't meet the 85% standard , the NHSDE requirement was achieved.

The Trust has an NHSE submitted trajectory for 2024/25, as part of operational planning guidance, to achieve for 62 day combined standard which sets out month by the month the expected level of performance. This is set to achieve 77.37% by the end of March 2024.

Healthwatch Wirral Commentary for Wirral University Teaching Hospital

Healthwatch Wirral (HWW) would like to thank Wirral University Teaching Hospital NHS Foundation Trust (WUTH) for the opportunity to provide a Commentary for the Trust's Annual Quality Account 2023/24

The Quality Account is a substantial document with considerable data, facts and figures. Therefore, we have focussed our commentary on the previous priorities and moving forward.

Foundations of Quality statement

The 'Foundations of Quality Improvement' should have what people tell us about their treatment and care at the heart of all we plan and do. We should be able to show that our actions and decisions reflect people's views. We must ensure that everyone is respected, involved, valued and confident that we are giving and receiving quality care.
Healthwatch Wirral, AgeUK Wirral, NHS England and ECIST, Wirral System.

1.Empowering Patients

Improvements appear to have been achieved within this Priority. HWW acknowledges the growing relationship with the Trust; which is evidenced through regular meetings, our presence at the Patient Experience Hub, invitation to attend the Promise Groups and wider activities. We look forward to our shared Event for Unpaid Carers on 8th June 'Putting Carers on the Map'.

HWW recognises the efforts of the Trust to enable patients to have their voices heard, and responded to, where there may be concerns or possible cause to complain.

HWW commends the proactive approach of the Patient Experience Team in working towards true co-production and empowering patients. A notable activity from the Trust has been regular attendance at HWW's BRIDGE Forum which enables the Trust to reach out to the community and workforce across the System. This has resulted in the Trust having a more diverse representation at the Promise Groups, as part of the Patient Experience Strategy.

HWW has supported the Trust in recruiting Patient Safety Partners by promoting and advising to help make this effort fully worthwhile. Improved systems to address and record patient safety incidents is acknowledged, by HWW, and we will continue to provide the correct balance of challenge/support going forward.

Working together we were able to identify barriers which may exclude some people within our communities. We look forward to being updated on lessons learned and how pathways and processes have been developed and embedded within the Trust to address those challenges.

Health Passports and Patient Portal - HWW would recommend that the functionality of the Health Passports and the new Patient Portal is as an area requiring ongoing attention and monitoring; if the Trust aim to enhance the patient journey, prevention and self-help.

There are still notable challenges in relation to Health Inequalities, meeting Public Sector Equality Duties and Accessible Information Standards. Mental Health, Advocacy under the Care Act/MHA and Place of safety remain a concern.

It is encouraging to see a joined-up approach to the next phase of EDS2022 working alongside WCHC, showing maturity and evolution towards better equity across our health system and improving the experience of people's health journeys. Integrated working, and sharing, could also include the alignment of Quality Impact Assessments and Equality Impact Assessment.

2.Safe Transfer

HWW recognise the considerable work that is in place around improving **Safe Transfer of Patients**. HWW has supported ongoing activities related to this, including significant work around Ward Folders. We, recently, were welcomed in the Transfer of Care Hub to see it 'in action'. This has been a notable achievement.

Based on patient feedback and the wider work of HWW, **Discharge from hospital** is still an area that should remain a priority for the Trust, and the wider system. HWW would continue to seek further clarity and assurance in regard to the Discharge process, approach, consistency and efficiency.

We maintain our stance around the importance of **good communication** prior to, during and after discharge ensuring transfer home is a good experience. HWW has been able to support this as part of the Pathway Zero work; speaking to patients and offering time and space to ensure that patients receive timely interventions helping to reduce the risk of a re-admission or attendance at A&E.

3.Improve Management of Deteriorating Patient

We note that this priority has been marked as partially achieved. HWW attended the Quality priorities meeting 19/03/2024 at WUTH.

It was acknowledged with WUTH staff and wider system colleagues that more work can be done in this area. E.g.

- Deconditioning whilst in hospital
- Hospital acquired infections
- Falls
- Delays around social care
- Significant benefits of exploring visiting hours and
- Utilising family 'triangle of Care'

Health Passports/carers passports have also been identified as a significant area that could help improve the patients experience during their stay.

HWW received positive feedback this year on the development of the C&M Surgical Centre at Clatterbridge, following a presentation by the Trust at the BRIDGE Forum. This is a great step towards revisiting clinical pathways, shortening waiting lists and improving patient journeys.

HWW are pleased to see emphasis being placed on the Trusts People Strategy and developing this culture of ensuring 'looking after ourselves and each other' and we can and will continue to support in relation this.

Report Author:- Micha Woodworth, Safeguarding & Inclusion Manager
On behalf of: - Karen Prior, CEO & Healthwatch Wirral
31st May 2025

Statement from NHS Cheshire & Merseyside Integrated Care Board (NHS C&M ICB) 2023-24

NHS Cheshire and Merseyside Integrated Care Board welcomes the opportunity to review and comment on the quality account for Wirral University Teaching Hospital NHS Foundation Trust (WUTH). NHS C&M ICB takes seriously our responsibility to ensure that the needs of patients are met with the provision of safe, high-quality services and that the views and expectations of patients and the public are listened and acted upon.

The 2023/2024 year has again proven to be challenging for WUTH, as the NHS continues with its recovery plans and the unprecedented impact of Industrial Action. NHS C&M ICB would like to commend the Trust and all its staff for the excellent commitment and dedication demonstrated throughout the last year. The WUTH Quality Account provides a comprehensive and transparent appraisal of both the quality achievements and challenges faced by the Trust over the past year and its aspirations for the coming twelve months.

The Trust has reported on the achieved improvement priorities during the 2023/24 year, and we welcome the development and sustainability plans to continue the progress into the 2024/25 planning. We will continue to monitor and review progress against these priorities through the established governance routes and welcome the opportunity to work with the Trust to ensure the needs of the Wirral population are met.

NHS C&M ICB notes the commitment from the Trust to involve patients and staff in quality and safety, we recognise that engagement with patients and staff is integral to achieving sustainable improvements. NHS C&M ICB fully supports the priorities outlined in the quality account for 2024/25 and welcomes that safe and high-quality care has remained a priority.

NHS C&M ICB support that Clostridioides difficile (C.difficile) infections feature as one of the key priorities for the 2024/25 targeted improvement areas. Reducing Health Care Acquired Infections is a key improvement area to ensuring that avoidable harm does not occur to patients while in the Trust. We recognise the ongoing improvement work by the Trust to reduce cross infection and improve communication and greater awareness. The learning from the rapid evaluations of care actions will need to be embedded to ensure an improved position.

The Trust has reported on seven of the eight agreed Commissioning for Quality and Innovation (CQUIN) frameworks during 2023/24. CQUINs are nationally set quality improvement indicators that support improvements in the quality of services and the creation of new, improved patterns of care. We acknowledge the performance reported for CQUINs as a true reflection within the account. We are pleased that a resolution to the unreported indicator has now been resolved and will continue to monitor through our local quality assurance processes. The nationally mandated CQUIN incentive scheme has been paused for 2024/25.

We acknowledge the Trust's last comprehensive inspection by the Care Quality Commission (CQC) was in 2019/20 and it is pleasing to note the ongoing focus improvements that further inspections have achieved, and we welcome the outcome of the Urgent and Emergency Care focused inspection.

During 2023/24 the Trust reported two Never Events. All Never Events are managed through the Serious Incident Framework and the ICB continues to work with the Trust to identify learning and appropriate actions, gaining assurance through the Serious Incident Review Group.

This year has been significant in relation to the Patient Safety Strategy and the implementation of the NHS Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE) risk management system. PSIRF and LFPSE is of particular importance to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. NHS C&M ICB is also pleased to note the plans around patient safety with a clear focus on reducing and eliminating patient harm. We note the active recruitment of Patient Safety Partners and recognise the Trust system partnership developments.

NHS C&M ICB commends the continued commitment to Quality Improvement and innovation of the Trust alongside increased collaboration and partnership working with the Integrated Care System. Whilst the Quality Account reflects the many areas of development, excellence, and good practice within the Trust, there are also areas of challenge that are acknowledged in the report.

NHS Cheshire and Merseyside ICB look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned over the forthcoming year to improve patient care, patient safety, and patient outcomes available for the population of each of our places.

Lorna Quigley

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Need Help or Advice?

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

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

Contact PALS

By Phone: 0800 432 0251

By Email: wuth.patientexperience@nhs.net

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