NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Quality Account

2024/25

together we will

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

Contents

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 2024-25, 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 in collaboration with system partners and Wirral Community Health and Care NHS Foundation Trust.

The Trust has been recognised by numerous national awards over the past 12 months within Maxillofacial surgery, Pharmacy Technicians, Physiotherapy, Urology, Health and Safety, Ear Nose and Throat and Haematology.

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:

- Governance support
- 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

The quality of our patient care is our top priority for the Trust and really important that we are able to publish the annual Quality Report for the organisation.

There has been continued challenge with pressures for our urgent and emergency care services while continuing to undertake a major redevelopment as part of the Urgent and Emergency Care Upgrade Programme. Wirral Diagnostics Centre opened its doors as the second community diagnostic centre at the Clatterbridge site, quality and patient safety continued to be at the centre of all decisions. While working within the wider landscape of financial challenges facing the NHS, quality patient care has been at the forefront.

The Quality Account recognises progress against all of the Trust quality priorities in 2024/25 which included a focus on reducing Clostridium Difficile Infection (C.diff), identification of the Deteriorating Patient, and effective communication and accurate reporting during transfer of care.

Improvement work relating to C.diff resulted in a reduction in cases, and that work continues. As part of Identification of Deteriorating Patient, there has been a Trust roll out of Call 4 Concern (Martha's Rule) following a successful pilot and a Treatment Escalation Proforma is also being piloted. We have fully achieved the priority to support effective communication and accurate reporting during transfer of care using an electronic SBAR communication handover.

The Quality Priorities for 2025/26 have been produced following a robust process to review learning from 2024/25. They have been co-developed through workshops with a wide range of internal and external stakeholders. The Qualities Priorities include Infection Control with a continued focus on C.diff, Management of Behaviours that Challenge, and Deconditioning.

With a continued drive to ensure to achieve clinical effectiveness across the organisation, the account shows our commitment to clinical audit and also to research as we make progress towards clinical excellence. We continue to promote research with the knowledge that high levels of research often result in better patient outcomes.

Quality can only be achieved with assistance from our workforce. Colleagues are encouraged to raise concerns and speak up. Our Freedom to Speak Up Guardian is an effective way for staff to raise concerns anonymously and help us to continuously learn.

This year saw an increase in the number of staff filling in their NHS Staff Survey which is a key component for understanding how our staff are feeling. This is mapped against the People Strategy and used to inform the priorities for the next year.

Safety Huddles held each morning have also given a forum for colleagues to raise any safety concerns and to learn from incidents. The Patient Safety Incident Response Framework (PSIRF) has continued to drive a significant shift in the way safety events are investigated across the NHS and has had a positive impact.

Patient Safety Partners, through volunteer roles, also offer an independent perspective on the Trust patient safety activity as well as a diverse perspective on potential quality and safety improvements.

The forthcoming year will no doubt be an exciting period. Improvement work has already started as part of our integration with Wirral Community Health and Social Care and that will continue to go from strength to strength as we share learning across both organisations. We will continue to use insight from data, clinical knowledge, patients and public so we can deliver our Quality Patient Safety Enabling Strategy.

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.

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 2024-25

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

1. Reduction in rates of Clostridium Difficile Infection

2. Identification of the Deteriorating Patient

3. Supporting effective communication and accurate documentation during transfer of care

2.1.1 Reduction in rates of *Clostridioides difficile* Infection

Not Achieved

The number of patients diagnosed with *Clostridioides difficile* infection in 2024/25 exceeded the threshold of 103 in the NHS Standard Contract 2024/25: Minimising rates of *Clostridioides difficile* having reported 167.

The *Clostridioidies difficile* QI programme commenced in July and a particular focus of the programme was to introduce quick win interventions to reduce rates of CDI on five wards. Key interventions included improved awareness with staff, patients and visitors, timely isolation, side room oversight and increased hand hygiene and IPC compliance.
The multi-disciplinary team, which includes the Improvement team, IPC team, and clinical staff, organised a series of meetings and events to discuss quality improvement initiatives focused on reducing *Clostridioidies difficile* infection rates.
This includes the *Clostridioides difficile* Showcase Event attended in November 2024, which was attended by a range of colleagues across all Divisions throughout the Trust:

The aim was to showcase the improvement work that has been introduced in focus areas to reduce rates of infection, and for those involved to share best practice and interventions that they have implemented in their areas.

Additionally, there have been several Trust wide communications to inform of the 5 key priorities launched with the 'It's not difficile' slogan. These have been in the form of information and awareness posters, newsletters, screensavers and Microsoft Teams backgrounds, awareness video. The *Clostridioides difficile* Change Bundle (sharing best practice) rollout has provided teams with a

reference guide in the management of patients and supported improved education and awareness throughout the Trust.

Recommendations following the Wirral wide review of CDT management that took place in 2023 concluded in August 2024 following which a 12-month *Clostridioides difficile* strategic plan was developed by the Directors of Infection Prevention & Control and the Associate director of Quality. The aim of the plan is to work as a system to reduce the rates of CDI throughout a patient's health journey, regardless of the provider of care. *T*here was an increasing trend from August 2024 to December 2024 reflecting initial disruption caused by the adoption of new processes and ways of working, however, since the establishment of defined decant and isolation processes (end of December 2024) we have seen evidence of reduction in the number of incidences. A period of embed and sustain has seen a shift away from special cause concern variation, with sustained improvement evidenced since the end of December 2024.

A key component of the programme is antimicrobial stewardship, which includes alerts for patients with prior infections and promotes limiting antibiotic courses to necessary durations to prevent potential harm from unnecessary antibiotic use. Infections are reviewed during weekly meetings with clinical managers, governance teams, and the IPC team using PSIRF-adapted paperwork. Identified themes, trends, and learning outcomes can then be shared to support and inform the ongoing improvement programme.

The Antimicrobial Stewardship priorities have been identified based on the 2024-5 Quality Contract and local priorities to support delivery of the AMR National Action Plan. For 2024/5 the standard contract does not contain antimicrobial prescribing targets and there is no longer a mandatory CQUIN for trusts to improve antimicrobial stewardship, however NHSE published a voluntary CQUIN to build on the work of 2023/4 CQUIN (03) IV to Oral Switch. The AMS team adopted this methodology to complete the audits proposed in the AMS audit plan, noting a reduced frequency and number of patients audited to allow additional priorities to be actioned.

In keeping with our Trust values, we must continue to promote and recognise the hard work that the teams deliver daily to help to keep our patients safe to sustain and maintain the improvements.

2.1.2 Identification of the Deteriorating Patient

Partially Achieved

The programme ended in March but support to NEWS2, Martha's Rule and Treatment Escalation Planning will remain in place up to the end of April.

NEWS2

All Divisions achieved above 90% with the exception of ED who achieved 84.35%. Within the ED data, RCA achieved 90.31% and Corridor managed 97.57% which is great to see.

Data is showing there is special cause improvement which is testament to the Ward's understanding their data and how to develop their own improvement plans.

MET Calls

Following the development and improvements to the MET call proforma there has been significant improvements especially from the surgical teams.

The team have also worked to improve cross speciality responses to MET calls. Surgical residents are now being encouraged to attend the evening MET huddle at the request of the Surgical Director.

Sepsis

This phase of the programme has highlighted several challenges. There is a delay in implementing sepsis model pathway and manual audit is required to establish compliance with the pathway. Despite the challenges, work continues with education being delivered to resident doctors, and all levels of clinical nurses. Advancing Quality data collection ceased in July 2024.

Call4 Concern (Martha's Rule)

The Trust have participated in a National Pilot for Martha's Rule/ Call 4 Concern which ended on 31st March 25. A small pilot has taken place on ward 38, ward 14, AMU, MSSW and UMAC to test the 3 components and the impact of the process on the CCOT.

There have been 12 calls of which 2 out of the 12 calls received led to adjustments being made to the plan of care.

Call for concern has been rolled out Trustwide in all inpatient adult areas. There is a dedicated internal number and mobile phone number for patients, relatives, and staff to call if any concerns. This will provide access to critical care outreach on a 24/7 basis for all adult patients.

Treatment Escalation Planning (TEP)

6 Consultants are in the process of piloting a new Treatment Escalation Proforma which will compliment all previous deteriorating patient projects and hopefully have a positive impact on our responses to medical emergencies. Following being piloted within the members of the QI group there are some improvements being made to the form, once this has been updated, the next stage will be to ask for more volunteers to use the form and assess for its impact on day-to-day ward work. Anecdotally the form has been positively received by nursing staff in ED and on ward 30 where it is being used the most frequently at present.

2.1.3 Supporting effective communication and accurate documentation during transfer of care

Fully Achieved

Transition to an Electronic SBAR (situation, background, assessment, response) communication handover as part of the EPR

The SBAR is now fully electronic and in use across the Trust with everything in one place, currently on version 6. This version reflects extensive stakeholder engagement, with valuable feedback helping to enhance the SBAR's usability and efficiency. Now, 80% of the SBAR fields automatically populate from prior documentation within the patient's care episode, reducing the likelihood of incomplete entries and addressing previous issues with SBAR completion. The adult assessment is not completed fully within the emergency department, this is completed at the point of admission to a ward.

The SBAR enables safe and accurate handover without the need for telephone handovers which can often delay transfers leading to an overcrowded emergency department and poor patient experience. Ongoing monitoring of the process is in place through quarterly audits which are presented at our Patient Safety & Quality Board.

Achieve compliance with completion of SBAR handover documentation on transfer

The tool includes the ward to which the patient is transferred, along with the name and role of both the staff member completing the handover and the one receiving it. The SBAR also includes the

patient's cognitive and mobility status and area to input the patient's reason for admission and ongoing plan of care.

The patient's resuscitation status remains on the main banner bar in the electronic patient record.

The documentation of patient property remains an area of focus. Additionally, there are specific SBAR exclusions that identify patients who require escort during transfer, such as those requiring a higher level of care.

SBAR-related incidents are closely monitored, with no incidents reported in recent months leading up to this report.

The SBAR handover does not negate the need for the registered nurse to read the patient's record following transfer for any clarification in the plan of care.

Improved Communication with external partners; GPs, Community Health Care Providers, Community Social Care Providers

1. Meeting with Cheshire West discharge team every Tuesday and Thursday to discuss progress with discharge plans for Pathway 1-3 Cheshire West patients in WUTH.
2. Fortnightly meeting with Wirral CHC team (CWP) to escalate any issues with discharge of patients who qualify for CHC funded care.
3. Daily (M-F) meetings with Home First team (WCHC and LA) to discuss current referrals and address any queries to avoid unnecessary discharge delay.
4. Monday, Wednesday and Friday meetings with Home First (WCHC and LA) and ToCH seniors to gain assurance of optimal flow into Home First.
5. Our Deputy Medical Director meets with GPs regularly at Local Medical Committee and Primary/Secondary Care Interface meetings and maintains good working relationships and an open dialogue with our colleagues in primary care.

2.1.4 Quality Priorities 2025/26

The development of the 2025/26 quality priorities has involved a robust process to review learning identified during 2024/25 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 with an initial list of 11 potential quality priority areas, this was provided to stakeholders who attended the quality priorities workshop in February 2025. This was an interactive session to agree which priorities had greatest potential to improve delivery of safe, personal and effective care. Following extensive discussions, this was narrowed down to agreement of the top three considering the impact of:

- Potential for harm to patients/staff
- Service Quality
- Public Confidence
- Financial
- Likelihood of reoccurrence
- Potential for new learning

This collaborative approach was 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 2025/26:

Quality Priority	*Success Measure*
Infection control – to include a continued focus on the reduction in rates of *Clostridioides difficile* and also to include a focus on reduction of Gram negative blood steam infections.	Achieve the standard contract threshold 25/26: Minimising *Clostridioides difficile* and Gram-negative bloodstream infections.
Behaviours of concern	Improved staff satisfaction demonstrated through the staff survey
Preventing deconditioning in patients	Increased number of patient who can sit out to do so

2.2.1 General Statement of Assurance

During 2024/25 Wirral University Teaching Hospitals NHS Foundation Trust provided and/or subcontracted the 88 relevant health services.

Wirral University Teaching Hospitals NHS Foundation Trust has reviewed all data available to them on the quality of care in all 88 of these relevant health services.

The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant Health Services by The Trust for 2024/25.

This year WUTH cared for:

	2023/24	2024/25
ED Attendances	96611	93130
UTC Attendances	36574	36616
Total	133185	129746
Births	2897	2896
Outpatient Attendance (all sites)	516340	525300
Inpatient Activity	63023	65067
Day Case Activity	49784	52774

WUTH employs 7423 substantive people. We engage with a large number of people through the bank system which raises this number to 7835. The employed people include 320 consulting doctors of which 5 are locum consultants.

2.2.2 National Audits

During 2024/25 the Trust participated in 87% (54/62) of National Clinical Audits applicable to Trust services. This is due to the wide range of Trust services with 62 out of a total of 88 national audits applicable to the Trust.

The Trust did not participate in 8 of the audits applicable to the Trust with details provided at the end of this 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 2024/25 are as follows:

National Programme Name	Division	Should we Participate?	Case Ascertainment
BAUS Penile Fracture Audit	Surgery	Yes	100%
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Surgery	Yes	100%

National Programme Name	Division	Should we Participate?	Case Ascertainment
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Surgery	Yes	100%
Breast and Cosmetic Implant Registry	Women and Childrens	Yes	100%
British Hernia Society Registry	Surgery	Yes	100%
Case Mix Programme (CMP)	Clinical Support and Diagnostics	Yes	100%
Emergency Medicine QIPs: Adolescent Mental Health	Acute	Yes	100%
Emergency Medicine QIPs: Care of Older People	Acute	Yes	100%
Emergency Medicine QIPs: Time Critical Medications	Acute	Yes	100%
Emergency Medicine QIPs: Mental Health - Self Harm (RCEM)	Acute	Yes	100%
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People[1]	Women and Childrens	Yes	100%
National Audit of Inpatient Falls (NAIF)	Medicine	Yes	100%
National Hip Fracture Database (NHFD)	Surgery	Yes	100%
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Corporate	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme[1]	Women and Childrens	Yes	100%
National Pregnancy in Diabetes Audit (NPID)	Women and Childrens	Yes	100%
National Audit of Care at the End of Life (NACEL)[1]	Medicine	Yes	100%

National Programme Name	Division	Should we Participate?	Case Ascertainment
National Audit of Dementia (NAD)[1]	Medicine	Yes	100%
National Audit of Metastatic Breast Cancer (NAoMe)[1]	Women and Childrens	Yes	100%
National Audit of Primary Breast Cancer (NAoPri)[1]	Women and Childrens	Yes	100%
National Bowel Cancer Audit (NBOCA)[1]	Surgery	Yes	100%
National Kidney Cancer Audit (NKCA)[1]	Surgery	Yes	100%
National Lung Cancer Audit (NLCA)[1]	Medicine	Yes	100%
National Non-Hodgkin Lymphoma Audit (NNHLA)[1]	Medicine	Yes	100%
National Oesophago-Gastric Cancer Audit (NOGCA)[1]	Medicine	Yes	100%
National Ovarian Cancer Audit (NOCA)[1]	Women and Childrens	Yes	100%
National Pancreatic Cancer Audit (NPaCA)[1]	Medicine	Yes	100%
National Prostate Cancer Audit (NPCA)[1]	Surgery	Yes	100%
National Heart Failure Audit (NHFA)	Medicine	Yes	100%
National Audit of Cardiac Rhythm Management (CRM)	Medicine	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Medicine	Yes	100%
National Child Mortality Database (NCMD)[1]	Women and Childrens	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)[1]	Medicine	Yes	100%
National Emergency Laparotomy Audit - No Laparotomy (NELA)[1]	Surgery	Yes	100%
National Joint Registry	Surgery	Yes	100%

National Programme Name	Division	Should we Participate?	Case Ascertainment
National Major Trauma Registry	Acute	Yes	100%
National Maternity and Perinatal Audit (NMPA)[1]	Women and Childrens	Yes	100%
National Neonatal Audit Programme (NNAP)[1]	Women and Childrens	Yes	100%
Age-related Macular Degeneration Audit	Surgery	Yes	100%
Cataract Audit	Surgery	Yes	100%
National Paediatric Diabetes Audit (NPDA)[1]	Women and Childrens	Yes	100%
National Perinatal Mortality Review Tool	Women and Childrens	Yes	100%
COPD Secondary Care	Medicine	Yes	100%
Adult Asthma Secondary Care	Medicine	Yes	100%
Children and Young People's Asthma Secondary Care	Women and Childrens	Yes	100%
Perioperative Quality Improvement Programme	Surgery	Yes	100%
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	Surgery	Yes	100%
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma skin cancers	Surgery	Yes	100%
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	Surgery	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)[1]	Medicine	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National	Clinical Support and Diagnostics	Yes	100%

National Programme Name	Division	Should we Participate?	Case Ascertainment
Haemovigilance Scheme			
Society for Acute Medicine Benchmarking Audit (SAMBA)	Acute	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Medicine	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Medicine	Yes	100%

National Confidential Enquires into Patient Outcomes and Deaths (NCEPOD)

Study Title	Participation	Project Status	%
End of Life Care	Yes	Submitted	33
Emergency (non-elective) procedures in children and young people	Yes	Submitted	80
Blood Sodium	Yes	Submitted	30
Acute Illness in people with a Learning Disability study	Yes	In Progress	patient data submitted

Non- Participation/Exceptions

- National Diabetes Footcare Audit
- National Diabetes Core Audit
- National Diabetes Inpatient Safety Audit
- National Diabetes Audit - Transition (Adolescents and Young Adults) and Young Type 2 Audit
- National Gestational Diabetes Audit

Diabetes team did not have the capacity to complete any of the national audits and the audit lead had left the Trust

- National Cardiac Arrest Audit – no participation due to capacity
- National Comparative Audit of Blood Transfusion - National Comparative Audit of NICE Standard QS138
- National Comparative Audit of Blood Transfusion

The lack of staff, primarily the lack of a Transfusion Practitioner, which have newly started in post

Plans are in place with Leads now assigned and these audits are scheduled to begin next year.

Outcomes and Learning from Clinical Audits Undertaken During 2024/25

The number of clinical audits both national and local which formed part of the 2024/25 Audit Plan are as follows:

Total Number of Audits in 2024/25 plan	Number of Local/Other Audits	Number of National Audits 2024/25 Including NCEPOD	National Audits from Previous Year	Number of Audits Fully Completed
336	271	58	49	55

Some of the key learning from 2024/25 is as follows:

National Lung Cancer Audit

Key Successes:

High surgical rates for non-small cell lung cancer, high proportion supported by Clinical Nurse Specialist and all indicators other than 1 in line with/above national average.

Key Concerns:

Indicator below average (and target)- path diagnosis stage 1-2 Performance Status 0-2 (78%, target 90%)

Systemic Anticancer Therapy stage 3B/4 good Performance Status - 59% (target 65%)

Curative treatment in stage 1-2 non-small cell lung cancer Performance Status 0-2 77% (target 80%)

Actions:

Work with CT dept for tracking CT scans on suspected cancer pathway for reporting urgently	Automatic recognition in CT dept of patients with CT requested for lung cancer for urgent reporting
NLCA- low histological diagnosis	Document on MDT for all PS 0-2 stage 1-2 why no pathological diagnosis (target 90%)
CT Biopsy Pathway	Improve system around CT lung biopsy
CQUIN data submitted quarterly	Closer monitoring curative treatment in good Performance Status stage1-2

National Paediatric Diabetes Audit

Key Successes:

Massive increase in technology uptake, especially in areas of deprivation, Continual improvement in median HbA1c, Coverage of key and additional health care checks is above national average and Compliance with Key Performance Indicators at diagnosis (screening blood tests and carb counting at diagnosis), Dietetic support and psychological screening are above national average.

Key Concerns:

The concerns raised are Increasing case load and deprivation, a drop in extra dietetic appointments, higher rates of high blood pressure and increased emergency admissions. Issue highlighted in the GIRFT review in November 2024 was need for increased admin support to ensure proper data capture (as funding re-imbursement for technology i.e. pumps and CGM) is now dependent on quarterly data submission. Action to address under review.

Actions:

Increasing case load	Capacity/demand review and business case
Higher rates of high BP	Continue BP monitoring at every visit. Consider 24-hour BP +/- medication for patients with persistent high readings
Drop in diabetes diet reviews	Ongoing monitoring of diet review coverage and arranging catch-up reviews via clinics, home visits or phone reviews
Need for accurate data reporting in real time	Ensure admin support for data entry
Need for ongoing structured education	Consider longer clinic appointments and diabetes educator appointments
High emergency admission rate	Consider expansion of psychology services or use of youth worker

National Oesophago-gastric cancer audit

Key Successes:

12.4% of diagnosis were following an emergency admission, which is below the national average at 13.1%. Dietetic support was good with 74% receiving pre-treatment support. 30-day mortality following surgery was 0.0%. 90-day mortality was 2.1%. 95.9% had more than 15 lymph nodes examined after surgery as opposed to the national average of 90.1**%.** 3.4% had +ve longitudinal margins, the national average was 4.9%. 17.2% had +ve circumferential margins and the national average was 21.5%.

Key Concerns:

Dietetic support was very good in 2020-2022, with 74% receiving pre-treatment support. This service is no longer available. Median wait to start curative treatment was 76 days, falling below by 14 days. Median wait to start treatment for non-curative treatment was 66 days, falling below by 4 days. Diagnosis following emergency admission is below the national average by only 0.7% and a low rate of HGD recorded.

Actions:

- **To highlight to Cancer Alliance & cancer lead**
- **To review weekly trajectories at weekly local MDT**
- **To educate MDT coordinators to record on SCR accurately with aid of HGD database**

National Audit- Pancreatic Cancer-NPaCA

Key Successes:

96 % Of patients were seen by Clinical Nurse Specialist at time of Diagnosis, 97% of people diagnosed 2020-2021 being discussed at multi-disciplinary meeting, 58% diagnosed within 21 days 65% at day 28 and 43 % treated at day 62. 70 % people diagnosed during 2020-2021 were prescribed Pancreatic Enzyme Replacement Therapy.

No concerns reported as all metrics above national average.

Actions:

- **Ensure all patients are reviewed in clinic and performance status is undertaken to ensure the appropriate approach is put in place to optimise patient general health wellbeing for treatment.**
- **Continuing with Referral to Community services Prehab Palliative Care District Nurse.**
- **Reviewing weekly trajectories to reduce waiting times.**

National Kidney Cancer Audit Report 2024 (NKCA)

Key Successes:

Expanded the scope of nephron-sparing surgery to include the most complex cases and a third surgeon has been trained in this procedure. An increasing proportion of radical nephrectomies and nephroureterectomies are being performed robotically, allowing better node sampling/dissection. Plans have been developed to train up another Consultant in robotic kidney surgery, to eventually take over the laparoscopic kidney cancer surgery performed by an existing senior surgeon. All patients potentially suitable for nephron-sparing surgery are discussed at our Renal SMDT following LMDT in peripheral units. Multi-Disciplinary Team triage for renal Sector MDT is now operational, with cancer cases managed as per the Mersey Standards of Care. All post-operative patients are considered for adjuvant treatment. Arrangements for surgical management of the most complex cases in Liverpool are now embedded and are actively participating in national trials for kidney cancer e.g. PARTIAL trial.

Actions:

Dependent on increasing robotic surgical capacity at Arrowe Park

National Inpatient Falls Audit Report 2024 (NAIF)

Key Successes:

WUTH has fully completed 2024-2025 National Audit of Inpatient Falls data entry ahead of deadline 31 March 25. WUTH are capturing real time data for Inpatient Falls for 2025 audit expansion.

Key Concerns:

NAIF 2024 results currently awaited but are likely to highlight KPI's need improving and will need increase in education programmes and CERNER updates.

Actions:

Trusts and health boards (HBs) should review their policies and practice to ensure older hospital inpatients are enabled to be as active as possible.	Trust wide working group set up. Planning to align with Falls Prevention and promoting Multifactorial Assessments to optimise Safe Activities (MASA). Await results of NAIF 2024-2025 data to allow benchmarking and provision of baseline data to monitor improvements.
NHS England and Welsh Government should implement national drivers to ensure that all older people are screened for delirium upon hospital admission using the 4AT and reviewed for changes **suggestive of a new onset of delirium for the duration of their admission.**	Delirium Screening Tool is implemented within CERNER. Previous local audits have shown improvements within DME.
Trusts and health boards should ensure that there are robust governance processes in place to understand when post-fall checks fail to correctly identify a fall-related injury.	Data to be presented at Fundamentals of Care Steering Group
Trusts and health boards should have processes in place to hasten time to administration of analgesia after an injurious fall, to ensure patients who sustain a femoral fracture in hospital are given analgesia within 30 minutes of falling.	Data to be presented at Fundamentals of Care Steering Group
Trusts and health boards are encouraged to prepare for the audit expansion in January 2025.	Completed 2024 data entry and actively identifying NAIF eligible cases and inputting 2025 data in real time.

National Non-Hodgkin Lymphoma Audit Report 2024 (NNHLA)

Key Successes:

Maintaining workload as one of busiest District General Hospital in region, good recording of performance status, good performance of clinical nurse specialist reporting, good BINET score staging

compared to region and nationally. Good MDT review within 4 weeks and good one year survival for low grade lymphoma.

Key Concerns:

Poor Ann Arbor staging but old data and methods to improve staging data have been put in place since then. Chemotherapy within 62 days of referral is average for region and UK, pathways have been put in place to continue to improve this position. Lower than regional and England average for 1 year survival, data difficult to benchmark due to low numbers.

Actions:

- **Compare ann arbor staging data with local data from newer years**
- **Compare 62 day waits for high grade lymphoma chemo with local cancer data**
- **To audit local HGL one year survival from local cancer data to see if improved**

National Neonatal Audit Programme 2024 (NNAP) – Comparison of 2023 data with 2022 data

Key Successes:

Areas of improvement were antenatal magnesium sulphate, delayed cord clamping, parent consultation within 24 hours, retinopathy of prematurity screening and breast milk feeding in first 2 days/at day 14/on discharge.

Key Concerns/for action:

Areas of concern/for action were antenatal steroids, temperature on admission, 2-year follow-up and type and duration of respiratory support.

NACAP (National Children and Young People Asthma Audit 2021-2024)

Key Successes:

On or above the national average for administration of steroids within an hour most years and on or above the national average for Personalised Asthma Action Plan usage.

Key Concerns:

Below average on documented discussions with patients and their parents / carers regarding smoking and below average on documented checking inhaler technique on discharge.

Actions:

- **Cerner Powerchart (for discharge paperwork) to be made and rolled out into all the services (inpatients, Paediatric Assessment Unit, Children's ED, H@H)**
- **Continued education from Respiratory Nurses to new staff members**
- **Wheezy Child >1 year Guideline updated on the intranet**

Local Audits.

The reports and outcomes of 50 local clinical audits were reviewed within 2024/25 at directorate meetings.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Acute Medicine	AC232410	Indications for checking vitamin D levels in patients admitted to Acute Medicine	Majority of patients had their Vitamin D levels checked in accordance with NICE guidance. Results shared in AMU Teaching sessions.
Acute Medicine	AC232411	Are patients with poorly controlled type 2 diabetes presenting to same day emergency care services being screened for MAFLD?	All known diabetes / high BMs had Hba1c test done appropriately. Not all patients with elevated HbA1c had fib 4 score done. Results shared in AMU Teaching sessions.
Acute Medicine	ACU242510	Hypertension Audit	Good compliance with U&E's, ECG, urine dip and documentation with clear follow up plan. Poor compliance with HbA1c testing and Fundoscopy. Poster completed and circulated. To re-audit in a few months.
Radiology - breast screening	CSD242510	Wirral & Chester breast screening Patient satisfaction survey 23/24	Excellent results obtained from this annual patient satisfaction survey. No formal action plan required; however, results will be shared with all teams and a re-audit is planned for 2024/25.
Radiology - breast screening	CSD242511	Breast Screening Assessment Clinic Patient Satisfaction Survey 23/24	Feedback from recalled patients is positive overall. Anxiety of returning patients has been highlighted, reaffirming the relevance of the breast care nurse role in supporting our patients during this recall process. Feedback from patients suggests that information is sought from friends, family and internet sources, which indicates that a review of the information the clinic currently provides should be reviewed to address any concerns or anxieties which our patients may raise.
Radiology	CSD242515	MRI WHO Checklist re-audit Q2	All aspects achieved 100% compliance, with the exception of 'interruptions'. Re-audit to be undertaken as planned, results to be cascaded to the team.
Radiology	CSD242516	Fluoroscopy WHO checklist re-audit Q2	• The majority of fields in Sections A & B scored 100%

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			• Training and awareness for staff completing forms was given. • Clear blank copied of the checklists are readily available. • 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 • Radiographers need to document the time, maybe this can be a separate question rather than Date/Time.
Radiology	CSD242518	Audit of IR(ME)R Employers Procedures compliance - X-ray & Fluoroscopy Q2	• 100% compliance was seen in all areas. This is an improvement from the last audit, where 100% was not achieved in DAP. • Data was again gathered from all WUTH sites, increasing assurance across department • Ongoing education via huddles and newsletter, to highlight importance of key areas.
Radiology	CSD242519	Audit of IR(ME)R Employers Procedures compliance - CT Q2	100% Compliance in all aspects of audit. Quarterly re-audit. Reinforce message to complete with process, via staff meetings.
Radiology	CSD242520	Audit of IR(ME)R Employers Procedures compliance - Breast Q2	The quarter was 96% compliant. Although justification and ID were 100% compliant, the recording of the dose has been below the expected target, although there is a significant improvement from Q1. Dose recording was less than 100% compliant, at 90% compliance. 1. Ensure all staff are aware of the findings through the modality huddles and monthly newsletter. 2. Cerner not meeting electronic requirements for compliance (on risk register and IT job currently in place).
Radiology	CSD242521	Audit of IR(ME)R Employers Procedures compliance - IR Q2	Overall compliance was 95%: • Justification – 95 % compliance • ID – 100% compliance •Documentation on Cerner for all patients. • LMP - 90 % compliance (on Cerner - this is checked as part of the WHO checklist, in which compliance is high) • Dose results – 95 % compliance • Justifying doctor sometimes completed the incorrect field, lowering compliance. • Ensure all staff are aware of the findings through the modality audit meetings. To reinforce documentation on Cerner as well as the

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Interventional "WHO" safety checklist to maintain high compliance. • Re-audit
Radiology	CSD242528	The accuracy of interpretation of emergency abdominal CT in adult patients who present with non-traumatic abdominal pain	Lower rates of discrepancies were seen in the onsite and registrar group. Better rates of correlation between reports and laparotomy findings were observed from on-site consultants and registrars. Final reports were available for all patients in surgical group audited, prior to their surgeries. Final reports were all available for patients within 24 hours of the initial report. Where discrepancies were noted as part of this audit, no harm was caused to any patients.
Radiology	CSD242531	Audit of IR(ME)R Employers Procedures compliance - X-ray & Fluoroscopy Q3	• 100% compliance was seen in 3/5 areas (Justification, ID, and IPS). • Data was again gathered from all WUTH sites, increasing assurance across department. • Compliance percentage dropped in 2/5 areas. For exposure factors compliance has dropped to 98.7%, and for DAP 97.5%. This is a drop from the last audit when both areas had 100% compliance. • Ongoing education via daily huddles and monthly newsletter, to highlight importance of key areas. • Cascade results of audits to staff and emphasise importance of ensuring compliance and maintaining 100% in all areas. • Re-Audit every quarter to ensure improvements are maintained.
Radiology	CSD242532	Audit of IR(ME)R Employers Procedures compliance - CT Q3	100% compliance demonstrated in all aspects of this audit: Justification, ID, LMP, Dose results This is the third quarter which has demonstrated 100% compliance. Quarterly re-audit. Share results and reinforce message of need to comply with procedures.
Radiology	CSD242533	Audit of IR(ME)R Employers Procedures compliance - Breast Q3	Compliance was 100% in Justification and ID. Compliance was 95% for dose results - documentation was found on Cerner for the majority of patients. Overall compliance was 96%, and a significant improvement has been seen when compared to the Q2 results. Less than 100% compliance was seen in one area of this audit - dose results.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Results to be shared with staff at modality huddle. Quarterly re-audit planned.
Radiology	CSD242534	Audit of IR(ME)R Employers Procedures compliance - IR Q3	100% compliance demonstrated during this audit, in all aspects audited: Justification, ID, LMP, Dose results. Justifying doctor was still sometimes documented in the incorrect field. Quarterly re-audit. Share results and reinforce message of need to comply with procedures.
Radiology	CSD242535	Audit of IR(ME)R Employers Procedures compliance - X-ray & Fluoroscopy Q4	• 100% compliance was seen in 4/5 areas (Justification, ID, IPS, and Exposure Factors). This is an improvement on the last audit (Q3). • Data was again gathered from all WUTH sites, increasing assurance across department. • Compliance percentage was still less than 100% for DAP. It has increased since the last audit but is still not 100%. • Ongoing education via daily huddles and monthly newsletter, to highlight importance of key areas. • Cascade results of audits to staff and emphasise importance of ensuring compliance and maintaining 100% in all areas. • Re-Audit every quarter to ensure improvements are maintained.
Radiology	CSD242536	Audit of IR(ME)R Employers Procedures compliance - CT Q4	• The quarter was 100% compliant in all aspects audited. This is a continuation for 100% compliance from the September 2024 audit. • Cerner not meeting electronic requirements for compliance (on risk register and IT job currently in place). • Repeat audit quarterly, to have more robust process and real time monitoring. This is a monitoring of process audit and will continue permanently. • Reinforced message to comply with process introduced via staff meetings following each data gathering period
Radiology	CSD242537	Audit of IR(ME)R Employers Procedures compliance - Breast Q4	The quarter was 96% compliant. Although justification and ID were 100% compliant Cerner not meeting electronic requirements for compliance (on risk register and IT job currently in place). Repeat audit quarterly, to have more robust process and real time monitoring. This is a monitoring of process audit and will continue permanently.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Reinforced message to comply with process introduced via staff meetings following each data gathering period
Radiology	CSD242538	Audit of IR(ME)R Employers Procedures compliance - IR Q4	100% compliance demonstrated in Justification, ID and LMP. 95% compliance demonstrated in Dose Results. Overall compliance = 95% Improvements seen in location of justifying doctor documentation and is now documented in the correct field following feedback. Less than 100% compliance demonstrated in dose results aspect of this audit (95%) Reiterate the importance of correct documentation and compliance with the process. Repeat audit quarterly.
Therapies	CSD242545	Improving Provision of Enteral Feeding in critically ill adult patients	All set standards audited were achieved: • All vented patients to have NGT placement and commencement of EN feed within 24-48hours of admission to ICU as per ESPEN (2023) recommendations. • All vented patients to commence the ICU feeding protocol to avoid overfeeding during the early period of illness (Day 1-3) of EN feeding as per ESPEN (2023) recommendations. • All vented patients to receive dietetic intervention within the late period of illness (Day 3-7) as per 'Guidelines for the Provision of Intensive Care Services' (GPICS) (2nd Ed., 2019) recommendations. • Gastric Residue Volumes to be monitored in all vented patients as per ITU feeding protocol (1st Ed March 2022). In addition, MUST was completed in 97% of cases audited. • To present the results of the re audit at the ITU MDT meeting to increase awareness, highlighting the importance of nutrition in the ITU setting. • To review evidence-based recommendations of ICU feeding protocols when needed.
Pharmacy	CSD242549	Antibiotic Point Prevalence	96% of antibiotics were compliant with the formulary / otherwise appropriate, this was an increase in standards from the 91% in 2023 Compliance with all AMS indicators have dropped slightly since the audit last year, with the exception of appropriate antibiotic choice. This could be due to the audit being undertaken a month after new junior doctors and pharmacists start in the trust, this is likely to influence both

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			the quality of prescribing and how rapidly pharmacist interventions are taking place. Indication documented in the notes 94% Aug 24 (95% March 23) Indication on the prescription 81% Aug 24 (88% March 23) Course length/eeview date documented 90% (94% March 23) 58% of all antibiotic prescriptions were for intravenous preparations (49% March '23) 250/319 prescriptions (78%) antibiotics had a documented review on Cerner, of the remaining 69 prescriptions, 32 were prescribed <72Hrs and 28 were for prophylaxis, therefore 9/319 prescriptions were not reviewed at 72 hours. •Re-audit co-amoxiclav use in ED minors once 5-day pre-packs have been embedded in practice •Continue to monitor IVOS twice yearly to monitor and ensure prompt switching to oral therapy
Pharmacy	CSD242588	Annual Pharmacy Medicines Storage Audit	Overall, the results of the audit were very positive, the control of keys was generally very good, as was locking of medicines storage areas and the management of bedside lockers in terms of security and their contents, with a few exceptions. Relatively few medicines were identified as being out of date and the management of emergency boxes and anaphylaxis expiries was also very good. The fluid storage was identified as generally good however, there is an opportunity to improve it further by improving the consistency of the storage of loose bags and potassium containing fluids. Following the identification of out-of-date medical gases as part of a CQC inspection, it was reassuring that there were no out of date medical gases identified during the audit. Communicate the finding of the audit to managers for each of the areas, asking them to highlight to staff the areas for improvement to ensure, Air Tube cupboards are locked, Liquid medicines have an expiry date endorsement when opened, medicines must not be left unattended on worktops, even in locked rooms. Refrigerated medicines need to be regularly maintained in terms of removing excess stock when it is no longer required and in ensuring that insulin vials are endorsed with a date of opening and are in date.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Medical gas cylinders must be stored securely in the racking provided, and empty cylinders must be returned to the gas store. Pharmacy to: • Liaise with Infection Control and Estates teams to assess medicines storage facilities with a view to establishing a rolling replacement programme. • Review of stock levels and storage capacity for each area and ensure that storage is adequate from a health and safety perspective. • Storage conditions for potassium containing fluids need to be standardised and as consistent as possible across the hospital • Review how the Computers on Wheels (COWs) are used to support medicines administration and, how security of their contents can be safely managed. • Review the Trust Emergency and anaphylaxis boxes paperwork to ensure or clarify that staff have visibility of the contents of trolleys in terms of their expiry dates.
Pharmacy	CSD242551	Medical Gases - Air Liquide	Little discrepancy between actual cylinders and those being charged for
Pharmacy	CSD242552	Q3 Controlled Drugs 2024/25	Generally, the results of the audit were very positive, albeit with the identification of a few areas which require improvement. In some cases, this in practice is related to attention to detail in the moment, by staff using the CD registers. Good practice identified: •Security, of controlled drug keys and stationery was excellent. •Compliance with daily checks very good, only a few areas missing a single daily check although one area was missing several. •Record keeping and governance was very positive in most areas. •All Patients Own Controlled Drugs except one had correct running balances. •Availability of rescue medicines (naloxone for opioids and flumazenil for midazolam) was excellent. Improvement work continues to be required to deliver full compliance with the CD regulations consistently in all areas. Attention to detail in recording individual transactions would improve record keeping, particularly around witnessing transactions. This

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			appears to be a problem that is commonly encountered in Theatres and ED. In several areas, staff need to be aware of the correct procedures in amending a CD register, in the event of an error that requires correction.
Pharmacy	CSD242553	Appropriate use of Pabrinex within the trust to treat and prevent Wernicke's Encephalopathy in alcohol dependent patients.	No patients experienced Wernicke's Encephalopathy 90% of patients had alcohol history recorded within first 48h of admission. 45% of patients who had a recent admission (within 2 weeks) had also received a course of Pabrinex® during previous admission. No actions as no longer stock Pabrinex. To share results for learning and revisit if returns to supply.
Pharmacy	CSD242589	Audit to assess the medicines delivery service at WUTH Pharmacy	The main success of the audit was the reduction in delivery services leading to cost savings for the department. There was not enough time to speak with patients to understand how this change would affect their care. Some important data was missing, especially reasons why patients couldn't collect their medication. Results will be disseminated as shows that delivery service incurs significant cost. However, prescribers did not always provide the reason for why medicines were being delivered. Prescribes must ensure that deliveries are only used for patients who really need them.
Critical Care	CSC242564	Evaluating current provision of end of life care within the Intensive Care Unit	100% of patients who had capacity had their priorities at the end of life discussed with them. 100% of relatives/next of kin/ representatives for patients at the end of life were updated and had discussions about priorities. 96.6% of patients were identified as dying CILDOL documentation- initial assessment complete – 23.3% CILDOL documentation- ongoing daily assessment complete, for patients who lived longer than 1 day once dying identified -37.5% Patients identified as in the dying phase in ICU will have a documented daily assessment of their physical symptoms - 33%. Patients identified as in the dying phase in ICU will have a documented daily assessment of their

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			requirement for artificial nutrition and hydration – 26.6% Patients identified as in the dying phase should have an assessment of their psychological, social and spiritual needs – 56.6%. Patients who are going to have life sustaining treatment withdrawn should have an individualised plan as to how this will occur documented in their notes - 63%
Therapies	CSD242570	Audit of the 2024 chronic kidney disease mineral bone disease biochemical parameters for haemodialysis patients attending Wirral University Teaching Hospital	Current audit demonstrates targets met by 51%, 96% and 69% of patients for phosphate, adjusted calcium and PTH respectively. More focus is required on patients with phosphate >1.7mmol/l. WUTH diet sheets and resources to be updated
Radiology	CSD242509	Image deletion re-audit	• Apparent reduction in image deletion incidents. • Reflective activity form introduced where patient is incorrectly scanned. • Worklist configuration change in Room 5 & 6 • Retraining/competency reassessment of operators and radiographers is eminent as every reason given is evidence of lack of training. • Overall continued non- compliance with reporting incidents where images are saved in the incorrect patient record. • Students in training need to be monitored by qualified staff & an SOP for training students available. • Image delete SOP need to be updated ASAP to reflect current changes. • Image delete form need to be reviewed to aid valuable data extraction • Employing a Practice educator/Deputy clinical Tutor – JMCF • Continue ensuring that staff report incidents when images have been sent to the wrong patient record outside the timeframe- Modality leads/PACS. • Develop an SOP/protocol for student in training, with emphasis on supervision. • PAUSED audit to be undertaken in various modality by lead for Quality Safety and Risk. • Reflective activity form must be used in event of incorrect patient exposure/unintended exposure- Modality leads

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Radiology	CSD242544	Re-audit of Abdomen X-ray Requests to Ensure Compliance with Departmental Protocols and IR(ME)R	95% Abdomen x-ray requests were made in compliance with Trust Guidelines. This is an improvement from the previous audit, which saw a compliance % of 91.55%. Discussion in house with Radiology team to ensure compliance with justification policy
Radiology	CSD242547	Biopsy re-audit	Generally high compliance was seen during this re-audit: 89% requests had laterality & location in correct fields. 10% requests had location and laterality documented in the wrong fields, or not included at all. Where no biopsy side/area was mentioned, this was sometimes found to be due to there being no specific preference (e.g. where pt had multiple nodes amendable to biopsy), leaving the choice to the consultant radiologist. Clinical lead to disseminate audit findings to teams to improve awareness of need to complete requests appropriately and fully. Re-audit
Radiology	CSD242567	Audit Report of Fracture Clinic Image Review to Ensure Compliance with IR(ME)R Employers Procedures (Retrospective)	• The audit was 100% compliant. There are no previous results to compare too. • An average of 2.5days for documentation to be viewable on the electronic record system for the patient to prove evidence of evaluation of x-rays were performed. Re-audit. Reinforce message to comply with existing process to Orthopaedics.
Cell Path	CSD242573	Audit on Histopathology reports mentioning "Best Tumour Block" and "Neoplastic Cell Content"	Improvement seen in increased reporting of best tumour block and neoplastic cell content in all cancer cases. Reporting of these helps identify the best block for further analysis. Whilst an improvement has been seen, there are still a high % of reports which do not mention best tumour block or neoplastic cell content. To reemphasize to the secretaries to keep mentioning the best tumour block and neoplastic cell content, while typing macroscopic findings. Consultants feel that is still not mentioned in all cases. Pathologists should also ensure reports mention best tumour block and neoplastic cell content under microscopic findings.
Cell Path	CSD242574	Re-audit - Histopathological	• P16 immunohistochemistry was used in 32/146 cases, including all cases of PeIN and SCC.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
		reporting and use of p16 in penile pathology	• Items were recorded as per the dataset. • 3 out of 17 SCC diagnoses had no stage stated. • Although it might not always be possible to state a stage in biopsies, the royal college recommends using the term 'at least' • LVI and PNI not recorded in 3 cases Remind the team to continue use of p16 in appropriate cases. Core dataset items to be entered - Proforma reporting to be used henceforth for biopsy and resections to capture this data.
Microbiology	CSD242579	Audit on clinical authorisation of blood culture results 2024	Major errors 0% therefore 100 % standard met. Moderate errors 0% therefore 90% standard met. Minor errors 5.7% therefore 80% standard met. The percentage of minor errors identified in this audit has significantly fallen since the last blood culture authorisation audit performed in 2023 which showed 3% moderate errors and 14% minor errors. Audit findings to be shared.
Microbiology	CSD242580	Audit of clinical authorisation of respiratory results 2023-2024	Major errors 0% therefore 100 % standard met. Moderate errors 0% therefore 90% standard met. Minor errors 60% therefore 80% standard not met. The percentage of minor errors identified in this audit has risen since the last respiratory authorisation audit performed in 2019 which showed 52% minor errors. However, the finding and trends in this audit are the same is in 2019. Although there were minor errors identified in this audit, they were deemed unlikely to have led to any harm. Recognise and Congratulate laboratory staff for high quality work. Targeted rectification of the identified trends Review how Aspergillus sp are processed and reported when isolated from Bronchoscopy samples. Address IT issues identified. Re-audit to monitor compliance and any further themes.
Radiology	CSD242586	Audit of Surveillance Mammography Recall Consensus 2024	NHS BSP Consolidated standards met: S07b Rate of referral for assessment: 3.9% (without consensus), 1.7% (with consensus); standard <4% S13b PPV of referrals with final outcome of cancer (invasive and in situ): 8% (without consensus), 17% (with consensus); standard >/=24%

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Audit shows consensus works - there has been an improved recall rate and increased cancer detection. Future re-audit.
Gastroenterology	MED 242532	Compliance with Photodocumentation	The audit found high overall compliance with JAG photo-documentation guidelines, with gastroenterologists performing best across all measures. However, significant improvements are needed in documenting reasons for non-compliance, particularly among colorectal surgeons and agency consultants. The findings emphasise the importance of adhering to comprehensive documentation standards to ensure thorough colon examinations and improve patient outcomes in colorectal cancer detection. Each endoscopist will be individually informed of their assigned numbers in reference to the anonymised results, and their respective performance.
Gastroenterology	MED 242537	Referrals to pancreatic IPMN Nurse led service	The results highlighted the significant increase in new referrals in the period of 2020-2024 which confirms the increased workload and need for additional support to continue working towards the IPMN standard framework and providing a continued high level of care and support to patients under the surveillance programme. To review audit and apply for funding for additional hours within the HPB team to support the management of IPMN patients.
Cardiology	MED 242540	Rapid Access Chest Pain Clinic Audit	Alternative service to hospital admission Aim is to deter costly and unnecessary tests being carried out. Reduce hospital bed stays. Allows specialist input and evaluation in outpatient environment. NSF (2000) for CAD recommend RACPC's for cardiology assessments within a 2-week time frame. The outcome from the audit is the criteria for referral to the rapid access clinic has now been established.
Respiratory	MED 242534	Assessing the prescription and monitoring of aminophylline infusions	Aminophylline is included in the respiratory department induction and the departmental teaching for pharmacists and junior doctors. Increased accessibility to the guidelines on the intranet and poster is under development. Where time to stop aminophylline was documented (26/35 prescriptions) there was a delay in stopping 46% of these prescriptions

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Mean stopping delay = 8.1h Currently conducting a second cycle of the audit to evaluate the impact of our interventions.
Trauma & Orthopaedics	Sur242536	Evaluation of PRP injections in soft tissue pathologies at Arrowe Park/ Clatterbridge Hospitals	Early figures. Only rolled out. But demonstrating safety, and reasonably cheap intervention. Clinic is working well. PROMS good to date. Plan is to reaudit when sufficient numbers and follow up to ensure efficacy and cost effectiveness. Likely in 12 months' time.
Trauma & Orthopaedics	Sur242539	Compliance with updated NICE guidelines for fixaction of hip fractures - Experience at APH	Retrospective audit including all extracapsular Neck Of Femur's who underwent fixation from Jan 2023- Dec 2023 • After excluding ineligible patients, total of 74 patients underwent fixations using either DHS or PFN. • 60.8% (45/74) patients underwent fixation using PFN, of which 13.3 % were AO 1/ 2.1, 44.4 % were AO 2.2 and 20 % were AO2.3/ AO 3. • Out of 6 patients (13.3%) with stable IT fractures who underwent fixation using PFN, two had previous history of metastasis, three patients were guided by the plan as per post-take ward round dictation and one had no specific reason justified. • The compliance at APH was still reasonable but there's still scope to enhance the utilization of DHS for stable extracapsular neck femur fractures as guided by AO classification. (AO 1, AO 2.1, AO 2.2) • 39 patients (87%) had PFN fixation for unstable fracture pattern which is very well justifiable and ethical. • To re-audit in 12 months
General Surgery	Sur242538	A non-randomized time-bound prospective observational cohort study addressing the management and outcomes of Small Bowel Obstruction	• Non-operative management with WSOC reported to have a success rate of 75% • Standard operating procedure for water soluble oral contrast administration and follow through • Involvement of specialist nutritional services should be considered in all patients. NASBO recommends nutrition team referral for all patients with SBO. • Average length of hospital stay of our patients was 13.75 days (IQR) with the longest being 73 days and the shortest was for 1 day. It was decided to bring down the number at the CG meeting.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
Neonatal	WAC242522	Does the use of prophylactic hydrocortisone to prevent chronic lung disease lead to any immediate complications in babies on the neonatal unit?	Comparison of an 8-month period following hydrocortisone introduction with the 12-month period of babies prior to the hydrocortisone introduction. The clinical problems reviewed were whether there was an increase in hyperglycaemia and insulin therapy; necrotising enterocolitis or bowel perforation; upper gastrointestinal bleeding; late onset sepsis. Conclusion – no statistical difference between the 2 groups for all the problems; however, the sample size was small. Able to provide some reassurance in the safety of prophylactic hydrocortisone use.
Neonatal	WAC242521	Electronic prescribing in the neonatal unit – a quality improvement project	Key error types were with: Antibiotics - dosing errors due to weight calculations, timing of benzylpenicillin. IV fluids - not discontinuing IV fluids on Cerner despite verbal decision to stop. Supplements - incorrect dose/volume calculations especially sodium. Caffeine - dosing errors due to dose & dose volume discrepancy. The action from this project was a list of common prescribing pitfalls compiled and put up on the doctors' office notice board for guidance.
Breast Surgery	WAC242528	Pathological response to Ductal Carcinoma in Situ (DCIS) to neoadjuvant systemic therapy (NST)	Outcome: A high proportion of patients with DCIS demonstrated a pathological response to NST. These findings underscore the value of post-NST imaging in evaluating treatment efficacy and support the potential for de-escalating surgical interventions, including breast-conserving surgery where appropriate. Actions: This study highlights a potential for change in clinical practice, this will however, need to be confirmed on a larger study. This audit provides a compelling rationale for a larger, multicentre trial.
Acute Paediatrics	WAC242545	An evaluation of the potential impact of same day viral PCR results on patient flow and individual patient experience	Key concerns: Length of stay and IV antibiotic treatment increased due to sending out of samples for Cerebrospinal fluid (CSF) viral PCR testing. Impact on patients with positive CSF viral PCR. Clinical decision to stop IV aciclovir often made prior to results being available- consultant decision requiring detailed discussion. IV access issues with aciclovir use - need for USS guidance/transfer out.

Speciality	Audit Code	Title	Post Projects Summary of Successes, Concerns and Actions
			Time spent chasing results. Key actions: Business case for rapid CSF PCR testing in house – consider collaboration with Chester due to shared microbiology laboratory. Audit could be extended further retrospectively or prospectively to gather more data. Can discuss need for follow-up (BPSU study shows <1% of those with enterovirus or paerecho virus meningitis develop severe neurological complications.
Acute Paediatrics	WAC242524	Lumbar Puncture Focus on Paediatrics: A Prospective Audit on Procedure and Documentation	Key successes: Lumbar puncture indications were clinically appropriate. Good success rate of procedure (89% procedure success rate) Cases of antibiotics given prior to lumbar puncture were clinically indicated. Key concerns: Overall suboptimal documentation around consenting and explaining procedure. Only 58% of lumbar punctures performed with paired glucose. Key actions: Educate department on outcomes of this audit; Update standard operating procedure to include details of required documentation. Complete audit cycle following execution of above actions

Review of 2024/25

The clinical divisions are responsible for their own audit forward planners with the central Governance Support Unit having oversight and reporting through Patient Safety Quality Board (PSQB).

Clinical Audit had reported into the Clinical Outcomes Group (COG) with the aim of strengthening visibility, assurance and allowing further divisional oversight. A further review of the governance of the audit cycle has been undertaken considering integration opportunities with Wirral Community Health Care NHS Foundation Trust (WCHC). This which will add value in the coming year and further support our improvement work.

In collaboration with WCHC, we have Identified opportunities for integrated working across the Clinical Governance portfolio which includes the strengthening of the clinical audit and effectiveness portfolio. This will enhance our Clinical Audit and Quality Improvement governance processes with an increased focus on evidencing improvement and sustainable outcomes. Furthermore, 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. There are arrangements in place to ensure this is delivered to colleagues in line with their roles and responsibilities.

2.2.3 Participation in Clinical Research

Overview of Research Activity 2024-25

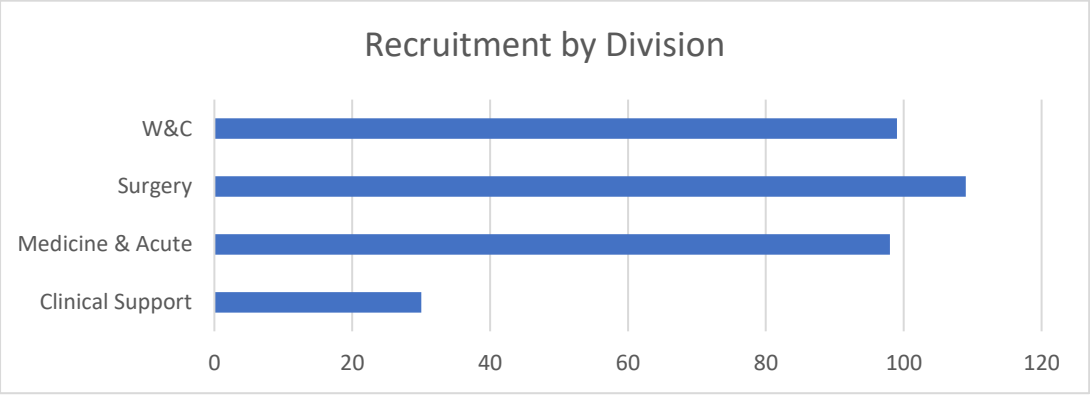
The main focus this year has been the refurbishment of the previous vaccine hub at the Clatterbridge site to create the Wirral Research and Innovation Centre. This was completed successfully within time frame and the centre was launched at the end of September 2024.

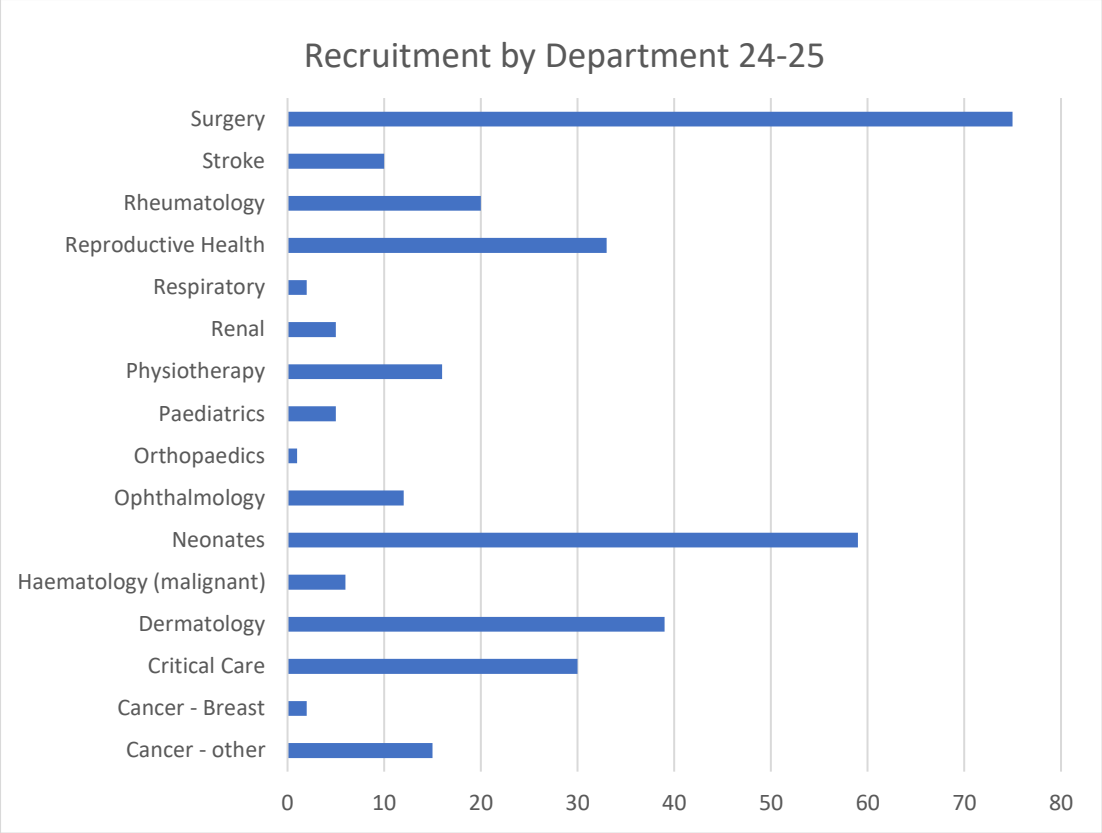
The centre offers free car parking for patients, a reception and consultation room, three clinical pods and a post intervention waiting area. It has a lab with -20 and-80 c freezers and centrifuge, and a pharmacy with 4c fridge and lockable medicine cabinets. The centre has a meeting room and separate site study file room with locked camber units for external monitors to attend the site in person.

We are confident that this facility will be an attractive site for sponsors to place their studies and that this will be seen as a centre of excellence for Wirral, Cheshire and Merseyside. So far one of the orthopaedic consultants is using the centre to see patients for his PhD but the plan is for three commercial studies currently in set up to be conducted there in the near future.

WUTH had an annual target of 700 new patients being recruited to studies from the National Institute of Health and Social Care portfolio (NIHR). Recruitment to date is 371 participants, but although the trust is not likely to meet the annual target this year, we are pleased to report a significant increase in activity in the Surgical and Critical Care portfolios. Studies in Women and Children (neonates and repro health) also continue to do well, see charts below.

The value of this target has been questioned and is under review by the Trust Research and Innovation subcommittee as it does not provide assurance around impactful research activity and does not support the objective of growing our commercial portfolio. For the 25-26 financial year the KPIs will be aligned to those from the Regional Research Delivery Network for the North West and include Time to set up for studies, percentage of clinical trials achieving recruitment target and number of commercially sponsored studies open.





Review of portfolio

Further rationalisation of the portfolio has been undertaken this year with 15 more studies being closed due to inactivity after discussion with Principal Investigators (PIs) and sponsors. Internal monitoring of study performance is an ongoing process, and a review has been introduced for all new studies three months after opening. Having cleared the portfolio, we have been able to consider taking on new studies where there are engaged and committed clinicians and have a number of studies in set up as per chart below:

Specialty	**Set Up**	**Expression of Interest/ awaiting site selection by sponsor**
Crit Care	MOSAIC, CORRECT	OXON-NS, ABBRUPT
Stroke	EASE, ASPIRING, LACI 3	CLASP, DO-IT
Women & Children	Starship, PANDA, Omega 3	
Urology	ELIPSE	
Respiratory disease	RASPER	Intermittent
Surgery	Wolverine, BioNTech, PINCER	
Orthopaedics	Rapsodi, FOREST	

A more streamlined study approval process was introduced to ensure robust feasibility not only of patient eligibility but also in terms of capacity of both the study team (PI and research nurse) and key study support services (pharmacy, pathology and radiology). This will confirm effective delivery of the research portfolio within recruitment timeframe and according to agreed local targets.

The revised process has been effective not only in having more confidence in the delivery of the portfolio but also in reducing study set up times, with the intention to complete study set up from site selection (receipt of local information pack) to opening within 40 days. So far, mean study set up times for this financial year are in fact 40 days.

In line with the Lord O'Shaughnessy 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. This year there have been three commercially sponsored studies opened at WUTH in Stroke, Surgery and Muscular skeletal disease. Three further commercial studies in Dermatology, Renal disease and Surgery are currently in set up. We are confident that once studies have been delivered effectively at the newly launched Wirral Research and innovation Centre at the Clatterbridge site, this will generate further interest from commercial sponsors to place their studies at this site.

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 (1.8 WTE). The Trust has also benefitted significantly from nursing and administrative support given by the Agile Delivery Team from The Regional Research Delivery Network for the NW, which currently amounts to 3.2 WTE. The team is managed by the Research and Innovation Manager works on a 0.7 WTE basis. She reports to the Interim Medical Director and meets with him monthly and the Clinical Lead for Research bi -weekly.

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.

WUTH have been able to expand interest and engagement in research through the NIHR 'Research Champion' initiative, and now have 7 actively involved Champions on board who contribute four hours a month to helping support the delivery of the study portfolio in the following areas:

Specialty	Number of RC's	Activity
Crit Care	2	Identification and recruitment to GeNomicc study
Neonatal	1	Admin support to Neogastric study
Midwifery	1	Identification and recruitment to Respires study
Ophthalmology	2	Potential support for study in set up

This initiative was beneficial for one of the initial Research Champions on Critical Care who went on to take up a post as a Research nurse at LHCH.

A Research Bank has also been set up and another RC from Crit Care has joined up to do additional shifts to help support studies in this area.

Collaborative working

WUTH continue to be a key partner of the Wirral Research Collaborative (WRC) which was set up to promote Primary-Secondary-Tertiary collaboration going forward. As yet, a suitable study has not been identified for us to work together on, but we maintain attendance at monthly meetings and hope that this will take effect in the near future.

Early discussions have been held with the Clinical Lead from the Wirral Community Trust with a view to thinking about how we can work together across sites, but we are also enthused by the potential from the Commercial Research Delivery Centre. This is led by LUHFT where central government would take place and WUTH would act as a spoke site for commercially sponsored studies.

With the newly launched research & innovation centre WUTH are in a very favourable position to participate in this initiative.

2.2.4 Commissioning for Quality and Innovations (CQUIN) Indicators

For the 2024/25 period, the mandatory CQUIN (Commissioning for Quality and Innovation) scheme has been paused. In its place, a set of non-mandatory quality indicators has been introduced. While these indicators are not compulsory, the Trust has contractually agreed to internally monitor two specific CQUINs for 2024/25. The two CQUINs being tracked are:

- **CQUIN10 – Early Stage Non-Small Cell Lung Cancer**
- **CQUIN11 – Shared Decision Making (SDM)**

These initiatives are a continuation of last year's reporting and reflect the Trust's ongoing commitment to quality improvement in these areas.

Final position shows the achievement of the 2 CQUINS, please see table below:

WUTH CQUIN 2024-25 Data Summary

		Target		Year End Performance
No	**Title**	**Minimum**	**Maximum**	**Q4 %**
CQUIN10	Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	80%	85%	91%
CQUIN11	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	65%	75%	93%

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 patient safety & 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.

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**

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.

The report following the Urgent and Emergency Care focused inspection in 2024 was published in November 2024. The overall rating from the inspection is Requires Improvement.

Summary

Safe	**Requires Improvement**
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-led	Good

The CQC inspection team spoke with staff, leaders and people who used the service and stakeholder organisations. The report stated that the Urgent and Emergency Care service mostly provided and maintained safe systems of care, in which safety was managed, monitored, and assured. Most processes and policies to plan and deliver people's care and treatment were in line with legislation and current evidence-based good practice and standards. However, the report found that people were not always cared for in the right place, referring to patients receiving care on the hospital corridor adjacent to the emergency department until a more appropriate setting became available. Following the CQC's site visit, they identified areas of concern which required immediate improvements and issued a letter to the trust about these. WUTH were able to provide assurance that the trust had taken immediate actions and put plans in place for longer term actions.

An action plan was developed following the inspection and is monitored through at the emergency department divisional quality boards and subsequently, the Trust's Patient Safety Quality Board.

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** **A planned surveillance inspection was undertaken for Histopathology in March 2025; however the outcome is awaited.**
ACSA Anaesthesia Clinical Services Accreditation	**Anesthetics**
GIRFT GETTING IT RIGHT FIRST TIME	**Trauma** **Elective** **Paediatric Trauma**
BSGE	**Women and Children's**
NJR National Joint Registry Working for patients, committed to excellence	**Surgery**

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. WUTH implemented a multiple

Guardian approach, with a designated Lead Guardian identified and since then, has been significantly involved in shaping national policy and guidance around this agenda and working hard to improve the speaking up culture within WUTH.

The Trust has been keen to continue support for the overall FTSU service and identified ringfenced time for the Lead Guardian role. 22.5 hours are allocated to support the FTSU lead role, with the lead role currently a shared post as Lead FTSU Guardian / People Experience Lead. A second FTSU Guardian is also in place, working in addition to their current role.

Guardians are supported by a network of 40 trained FTSU Champions, whose role is to work within their service areas, promoting and encouraging staff to speak up and signposting to the FTSU Guardian.

Where a member of staff does not feel able to speak up through the normal management channels, they are encouraged to contact the 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. Guardian walkabouts take place across the Trust 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 2 received in 2024/25, which can be a good indication that staff continue to feel confident in approaching the FTSU Guardians or local management teams.

The 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.

Our 2024/25 data shows a reduction in a number of people accessing the FTSU service, however those that are, are accessing the FTSU service across all Divisions and a range of occupational groups.

Numbers of staff speaking up regarding patient safety has increased and falls in line with national data. Regional comparators have an average of 6 patient safety concerns raised per quarter.

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 2025/26.

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 continues to operate a joint working protocol between the FTSU Guardian 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 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 WUTH staff networks. A number of staff network members (including LGBTQ+, Multicultural, staff with disabilities and long-term conditions, the menopause network and 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 because 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 2024/25 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%	92.3%	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.

At the end of March 2025, the Trust will undertake Phase 1 of the required annual audit of the Data Security and Protection Toolkit (DSPT). This is undertaken by Mersey Internal Audit Agency. Phase 2 of the audit is scheduled for 27th May. Last year 'Substantial Assurance' was achieved in each of the 13 areas. This resulted in achieving 'Substantial Assurance' overall in the 2023/24 MIAA external audit.

NHSE changed the submission date for the DSPT from March to June so the final submission will be at the end of June 2025. However, the Trust achieved 'Standards Met' in the 2023/24 submission in June 2024.

The main focus for the year has been to understand and adapt to the newly aligned DSPT, which is now based on the Cyber Assessment Framework (as opposed to the National Data Guardian Standards previously). This means there has been an increased focus on cyber security performance and both cyber and Information Governance have new requirements to evidence.

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.

Four data breaches have been reported to the Information Commissioner's Office (ICO) by the Trust to date (see table below) as they all met the threshold for reporting. In addition, a third-party supplier, Medequip, reported to the ICO that they had experienced a cyber-attack. Most of the Wirral data originated from GP surgeries and the incident only involved WUTH data of three patients.

ICO Number	Date	Incident Details
IC-299292-C4B9	April 2024	Missing paperwork via a courier. Status: Open – Awaiting response from ICO.
IC-346408-Q0T7	November 2024	Cyber security incident. Status: Closed – no further action
IC-355337-L9Q2	January 2025	Confidential data disclosed in a discharge letter. Status: Closed - no further actions.
IC-365158-G1R2	February 2025	Inappropriate access to the Electronic Patient Record. Status: Open

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 2024/25 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 101 episodes discharged under Diabetic, Respiratory and General Medicine specialities performed in July 2024. The overall accuracy of our coded data was reported as:

Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
92.00%	95.57%	96.43%	96.83%

A second audit was performed on Colorectal, Upper GI and General surgery discharges was performed in September 2024. The overall accuracy of our coded data was reported as:

-

Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
94.00%	94.00%	98.30%	96.36%

These external audits were supplemented with additional internal audits throughout the year focusing mainly on the accuracy of individual coders. We have three Approved Clinical Coding Auditors in post. The cyber incident resulted in a sustained period of downtime with subsequent impact on the completeness of coding. Recovery of the coding position has had an impact on the internal audit programme.

The Trust will be taking the following actions in 2025/26 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.
- Exploring the use of digital solutions to support the clinical coding process.

We continue to support staff development, this year three staff passed the National Clinical Coding Qualification becoming Accredited Clinical Coders. Three staff maintained their Approved Auditor and Trainer status. Recruitment of trained staff remains challenging, and retention of trained staff is becoming more difficult with a pronounced pay differential between English regions

2.2.11 Learning from Deaths

During 2024/25, 1,794 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:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
418	432	471	473

The Medical Examiners (ME) continue to maintain independent 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 2024/25 a total of 151 mortality reviews received further review. This consisted of 44 Escalated Mortality Reviews, 97 Quality Assurance PMRs and 10 Learning Disability 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 6 LeDeR reviews between 1st April 2024 and March 31st 2025.

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
21	48	41	41

Learning identified through review of mortality reviews

Learning for mortality is derived from 3 main sources.

- Mortality reviews (collated into a learning log)
- Themes and trends escalated from the Medical Examiner
- Learning identified through the PSIRF process.

Specific learning and themes identified as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
DNACPR forms are not always fully completed	Mortality reviews	Learning is fed back on an individual basis in real time. From April 2025 the Trust will be participating in the national cardiac arrest audit (NCAA) that will help identify learning
Medication errors (not causing harm)	Mortality reviews	All medication errors are fed back to relevant clinician. If a medication error has resulted in possible harm this is picked up under the PSIRF process. Themes and trends are discussed at MSOP and feedback to all clinical areas
Missed opportunity to prescribe aspirin	PMRT	Aspirin protocol reviewed to ensure high risk patients are not missed
Nosocomial Infections prolonging length of stay	Mortality reviews	SOP for side room allocation reviewed. Proactive HPV cleaning programme initiated for C Diff cleans
Poor documentation/ copying and pasting of medical documentation (not affecting patient outcome)	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads. The EPR template has been adjusted to remind staff not to copy and paste notes as routine.
Poor thermoregulation during 1st day of life	PMRT	New process in place to reflect national guidance

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 meetings.

2.3 Reporting against Core Indicators

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

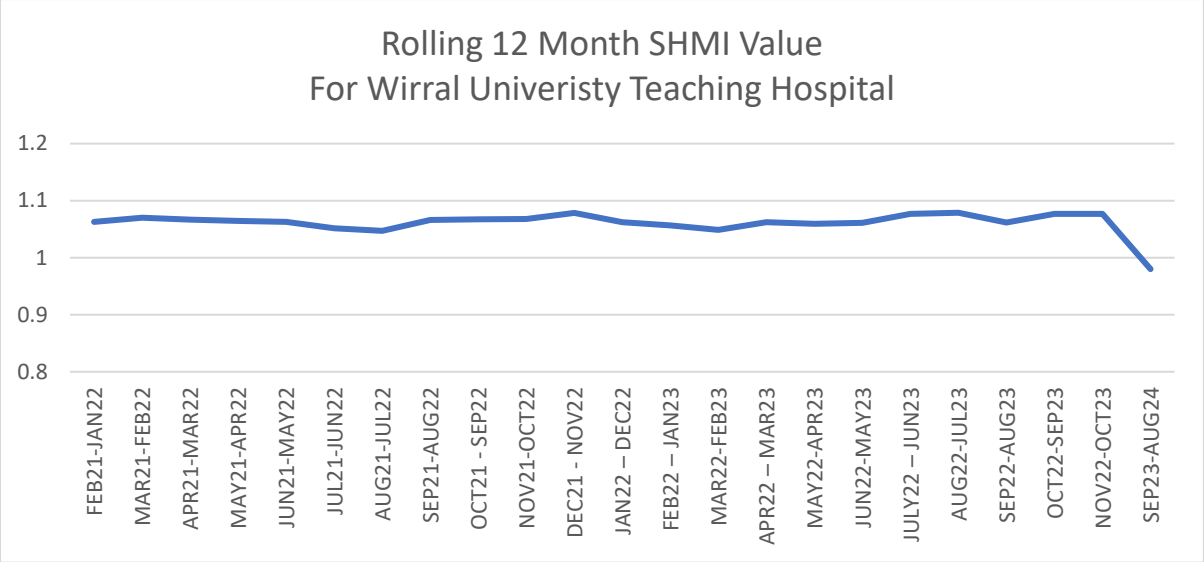
The SHMI is the ratio between the actual number of patients who die following hospitalisation at WUTH and the number expected to die on the basis of average England figures taking into account the patient cohort and acuity of WUTH. SHMI gives an indication for each non-specialist acute NHS Trust in England whether the observed number of deaths with 30 days of discharge from hospital was 'higher than 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 9th January 2025) 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
SEP23-AUG24	0.98	2

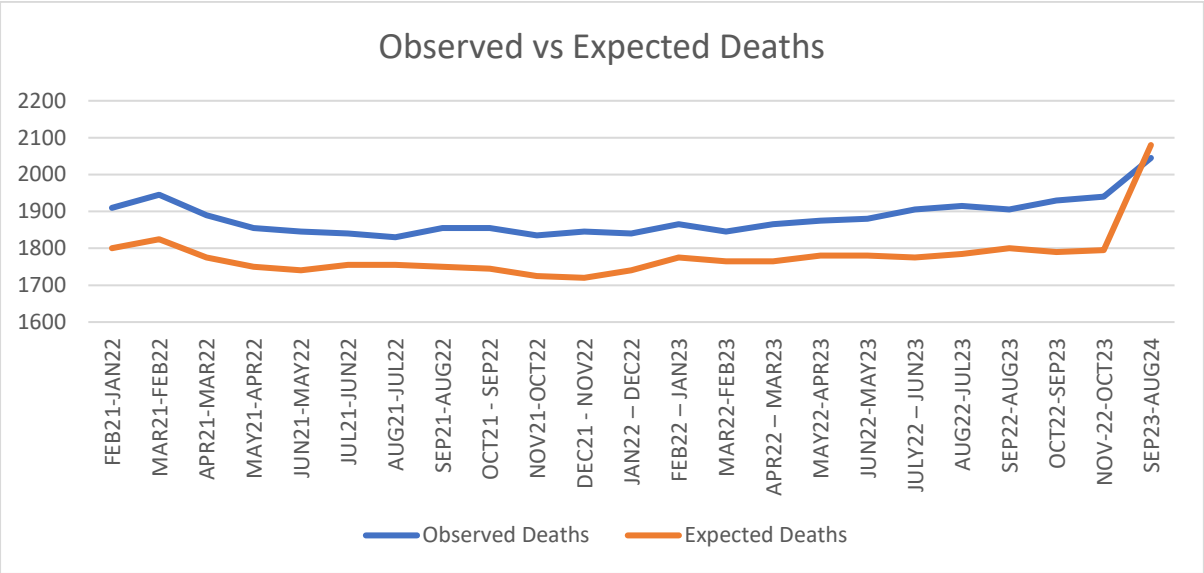
The graph below shows the SHMI 'as expected' for WUTH for the past 3 years.



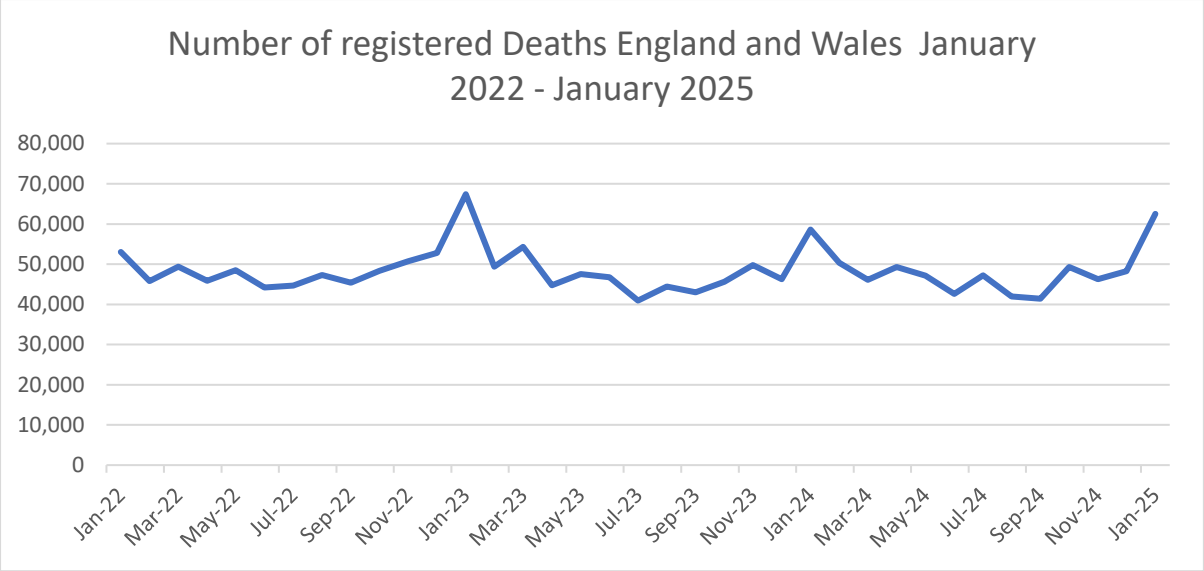
Several changes were made to the SHMI methodology in May 2024, including:

- Inclusion of COVID-19 activity for discharges on or after September 1, 2021.
- Exclusion of hospice sites within non-specialist acute trusts.
- SHMI values will only be calculated for a subset of sites in the site-level breakdown.
- Updates to the methodology for identifying primary and secondary diagnoses in multi-episode spells.
- Activity with an invalid primary diagnosis will be placed in a separate diagnosis group.

Following these changes, the trusts SHMI value has demonstrated a general downward trend.



When we examine the observed and expected death over the last 3-year period, we see that despite fluctuations the observed deaths are higher than the expected deaths for the Trust, apart from August 2024. 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.



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

2.3.2 WUTH Patient Reported Outcome Measures (PROMS) – Hip and Knee Replacement Procedures

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

Hip and knee replacement procedures are commonly performed high-cost procedures and therefore NHS institutes are mandated to collect data to support evidence of appropriate patient selection (i.e. not operating on patients too soon or too late in the pathway) and to evidence a significant health improvement post procedure. This in benchmarked against other NHS units in the UK.

The data is collected centrally using a pre-operative questionnaire (Q1) and post-operative questionnaire (Q2). The post-operative questionnaire is sent to the patient from a central NHS team at between 6 and 12 months post procedure, this leads to a lag between operation date and result publication (hence why the latest results available are 23-24).

Three validated outcome questionnaires are utilised: the Oxford Hip/Knee Score (a joint specific health tool), the EQ-5D (a general health outcome tool) and the EQ-VAS (single metric of perceived health).

Ensuring patients completed the first questionnaire pre-operatively was a challenge around the time of the pandemic because of the non F2F joint school however since F2F has been reintroduced we have a robust mechanism to enrol patients and explain the importance of completion. This has resulted in a greater completion rate for the 2 questionnaires giving us more robust data.

For Hip Replacement Surgery we had 145 patients return both Q1 and Q2. Significant improvements were noted in both the EQ-5D, the Oxford Hip Scores and EQ-VAS scores. These improvements are reported by NHS Digital as within the expected findings (Fig 1).

For Knee Replacement Surgery we had 166 patients return both Q1 and Q2. Significant improvements were noted in both the EQ-5D, the Oxford Knee Scores and EQ-VAS. These improvements are reported by NHS Digital as within the expected findings (Fig 2).

The data now includes a breakdown of the pre-operative and post-operative Oxford Hip and Knee Scores as compared with the national average. The aim of this is to ensure that patient selection and outcomes are in keeping with “national selection” criteria. It appears WUTH results for both hip and knee selection and outcome look acceptable with no obvious anomalies (Fig 3 & 4).

Fig 1

Total Hip Replacement 2023-2024 Data published February 2025		
EQ VAS	**EQ-5D Index**	**Oxford Hip Score**
13.336 Not an outlier	0.460 Not an outlier	21.547 Not an outlier

Fig 2

Total Knee Replacement 2023-2024 Data published February 2025		
EQ VAS	**EQ-5D Index**	**Oxford Knee Score**
5.690 Not an outlier	0.347 Not an outlier	17.224 Not an outlier

Fig 3

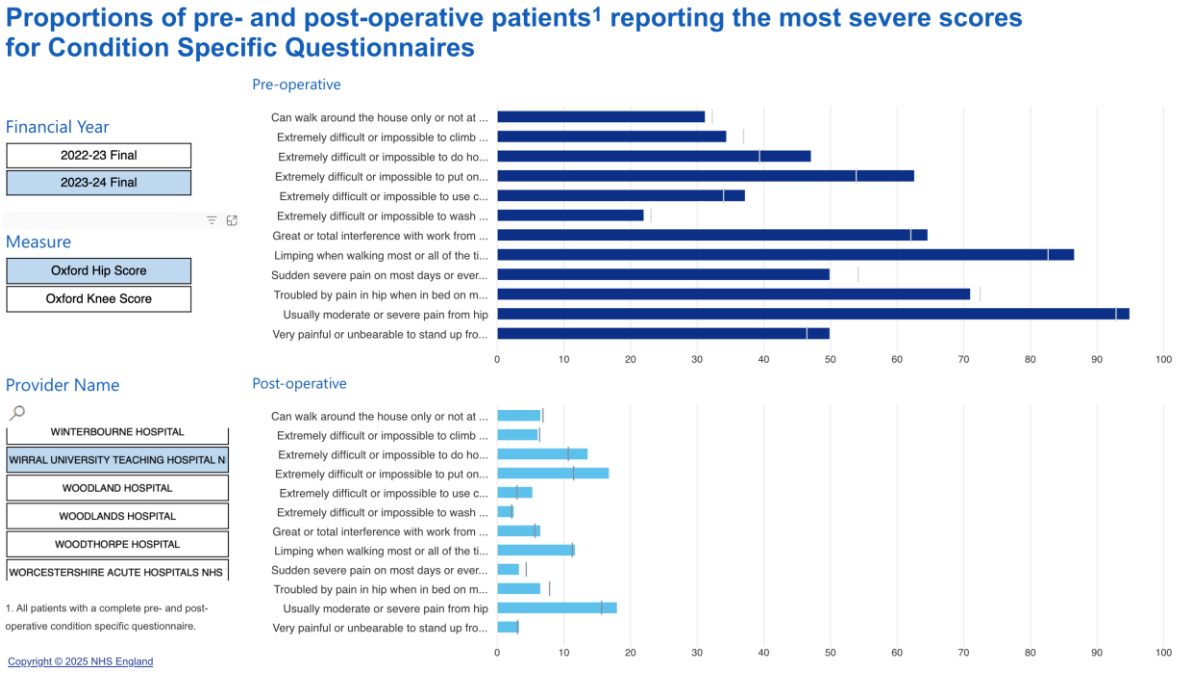
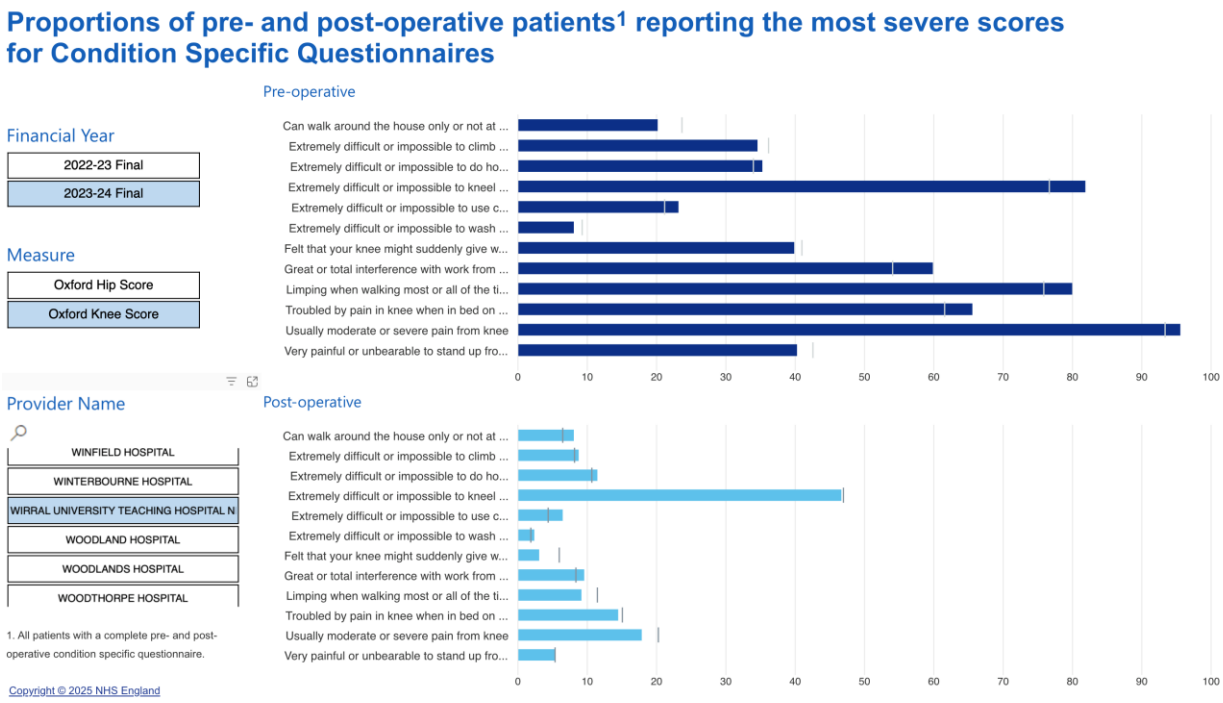


Fig 4



Summary –

The Trust's Trauma and Orthopaedic Directorate are fully engaged in the PROM's process for primary hip and knee replacement patients.

We have good enrolment and participation data (other local units are still not ensuring adequate numbers to obtain published outcome data).

Our selection criteria appear to be within national benchmarking and our outcomes with regards general health improvement and joint specific improvement are within expected levels.

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.

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	2022/23 (Banding)	2023/24 (Banding)
<16	19.0 (A1)	16.9 (A1)
16+	11.9 (B1)	12.8 (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 is actively working to improve this indicator and the quality of its services by:

- Enhanced Discharge Planning: Daily multidisciplinary board rounds to ensure medically optimised discharge.
- Follow-up Services: Expansion of our virtual wards for frailty and COPD patients
- Community Integration: Strengthened partnerships with primary care, district nursing, and social services to ensure continuity of care after discharge. Closer integration with the Community Trust to streamline pathways and services over the next 12 months.

1.3.4 Ensuring People have a Positive Experience of Care

The Trusts responsiveness to Personal Needs of its Patients

WUTH is committed to ensuring that its patients and service users have a positive experience. The Friends and Family test is a primary source of patient experience monitoring data used within the NHS. During 2024 / 25 WUTH maintained consistently for each month a recommend rate of ≥95% for adult inpatients. Direct comparison with other NHS organisations demonstrates that WUTH's FFT performance for other services such as Maternity Services, Emergency Department (ED) and Outpatients are in line with national and peer averages.

During 2024/25 the CQC have published 3 patient experience national surveys. CQC banded WUTH as "Better" than other organisations for 5 indicators within the 2024 Urgent and Emergency Care Survey and were identified as in the top 5 performing organisation regionally for 8 out of 11 sections, these sections focused on areas of communication, overall satisfaction and privacy and dignity, whilst WUTH was not banded as "Worse" for any indicators, it was identified in the lowest performing regional Trusts for the section on arrival. WUTH continues to focus on enhancing the experience of service users within the ED including the progression of its new Urgent & Emergency Care build. The 2024 Maternity Services Survey also highlighted WUTH as "Better" than other organisations for 1 indicator and in the top regional organisations for 4 out of 9 sections. There were no sections banded as "Worse" than other organisations by CQC, however WUTH were highlighted in the lowest performing Trusts regionally for the section of "feeding your baby". WUTH has a strong working partnership with Wirral Maternity & Neonatal Voices Partnership and continues to work closely to support the needs of the community in this area. The 3rd publication was in relation to the 2023 Adult Inpatient survey results. All results are available for review Surveys - Care Quality Commission

Staff Recommend the Trust as a Provider of Care to Their Family and Friends – 58%

The NHS Staff survey is conducted annually. WUTH has achieved an impressive response rate in this year's NHS Staff Survey, with 47% of staff sharing their views - an increase from 38% last year. This rise reflects the commitment of our staff to shaping the future of our Trust and follows the launch of our 'It Starts With You' campaign, which encourages every staff member to share their voice and drive positive change.

Indicator from 'We are Compassionate and Inclusive'	2023/24	2024/25	Benchmark
I feel my role makes a difference to patient/service users	86.68	86.90	Below national average
Care of patients / service users is my organisation's top priority.	69.01	64.97	Below national average
My organisation acts on concerns raised by patients / service users.	65.25	62.96	Below national average
I would recommend my Organisation as a place to work	56.20	52.80	Below national average
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	64.58	58.13	Below national average

Wirral University Teaching Hospital is below the national average in the above 5 indicators. WUTH already has held workshops with senior leaders, corporate service heads, and key strategy leads to review the findings and identify focus areas for the coming year.

There was a dedicated online event on the morning of Thursday 13th March to share results and next steps with staff. There will also be further staff engagement sessions organised to ensure all voices continue to be heard.

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.

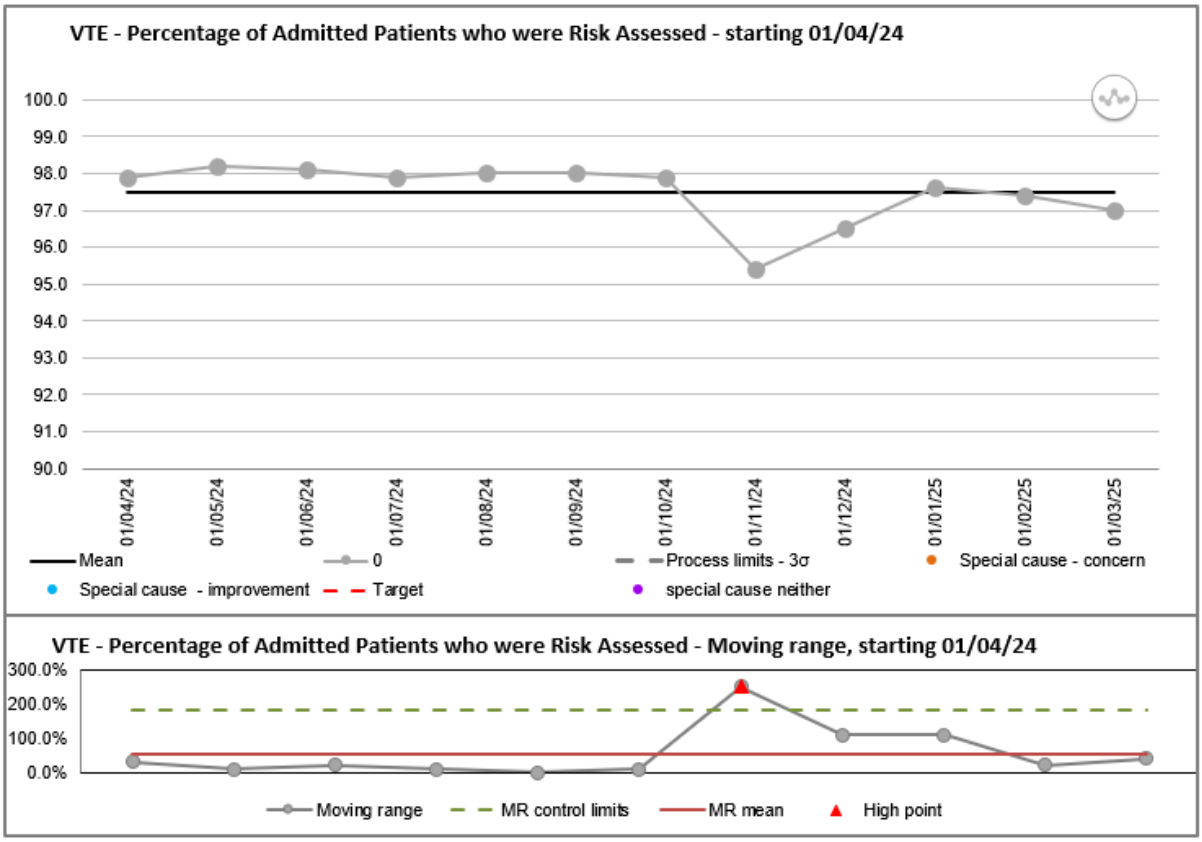
The trust's VTE policy (POL 199 VTE (Venous Thromboembolism in Adults (The Prevention Management of)) states that:

- 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 may not be completely accurate for March as data is amend retrospectively to remove patients who do not require VTE assessment. Also, the data for November and December may not be completely accurate due to Downtime.

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.

2.3.6 *Clostridioides difficile* Infections

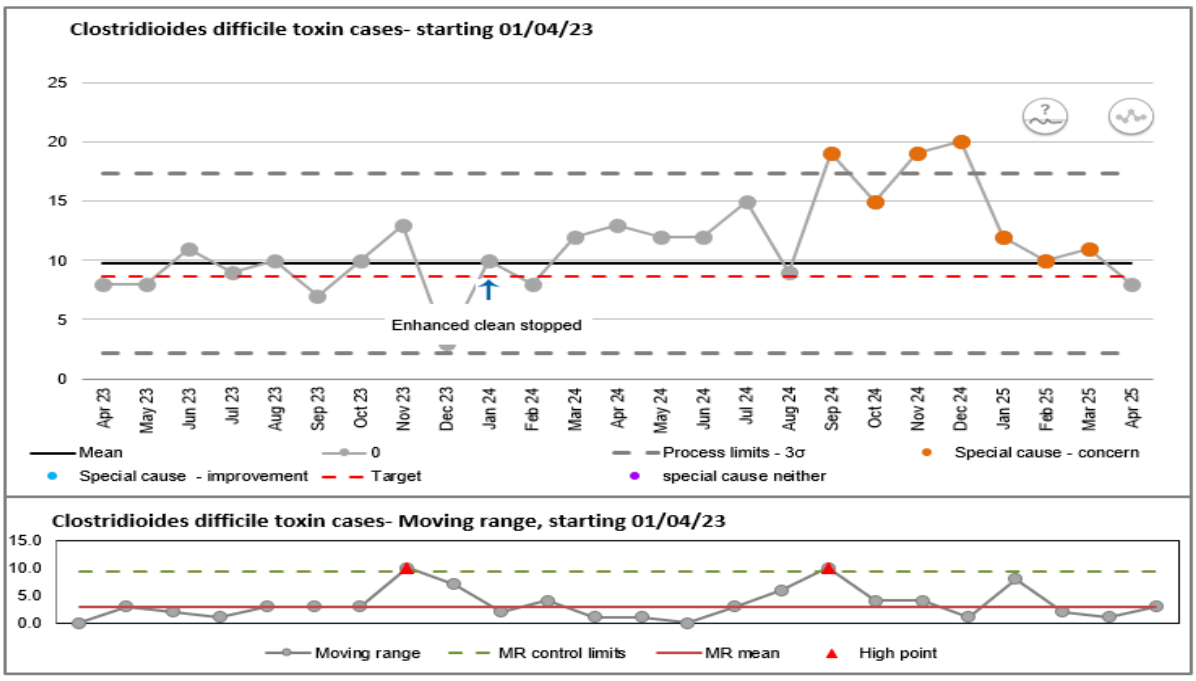
Clostridioides difficile is recognised as a significant healthcare associated infection and multiple infection control measures and treatment modalities have been looked at, this continues to be an evolving field. Recent guidelines suggest that the management of severe CDI should be considered a medical 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.

As was in the previous year, the NHS Standard Contract 2024/25 includes quality requirements for NHS trusts and NHS foundation trusts to minimise *Clostridioides difficile* (*C.difficile*) and Gram-negative Bloodstream infections (GNBSIs) rates 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 2024/25 was set at 103.

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.

As for previous years in 2024/25 trust level thresholds comprise total healthcare-associated cases (i.e., HOHA and COHA).

Executive support to enable implementation of the fundamentals that are recognised as proven reduction strategies for CDI, like the reactive and proactive decant programme which supports real time Hydrogen Peroxide Vapour cleaning of the patient environment where infectious patients have been nursed has contributed to the decline in numbers reported in Q4 as seen below. whilst there is clearly still improvement to be made, we can evidence that we have closed the gap against the regional average in Q4 and hopefully maintain that going forward.



Performance
Whilst performance in 2023/2024 (109 incidences) had improved there were indications in Q1 of 2024/25 that infection rates were beginning to rise, with cumulative figures for the first three months of the financial year (38 incidences) significantly surpassing the figures reported during the equivalent period in 2022/2023 (31 incidences).

Quality Improvement programme
The C*lostridioides difficile* Quality Improvement Programme commenced in July 2024, with C.diff improvement having been identified as one of the three key quality priorities for WUTH in 2024/2025.

Stretch target
At the commencement of the improvement work (mid-July 2024) the threshold set out by the 2024/2025 NHS Standard Contract for WUTH (103) was deemed unobtainable within the programme scope, with WUTH at 36.89% to the full year target at the end of Q1. Therefore, the *Clostridioides difficile* Quality Improvement Programme Team devised a stretched target which would form the scope of this improvement programme.

A SMART approach
A SMART (Specific, Measurable, Achievable, Realistic and Timely) aim was subsequently defined, with a scope to deliver month-month improvement in hospital attributed (HOHA and COHA) CDI between August 2024 end of March 2025. The Programme Steering Group identified key milestones that would track progress and delivery.

Opportunities for improvement
Environmental observations, tracking of positive patients and analysis of themes and contributing factors identified a multitude of causative issues, all of which offered opportunity for improvement, with subject matter expert interviews defining areas of focus.

Communication
Improving education and communication was identified as essential in reducing rates of *Clostridioides difficile* infection at WUTH. Awareness campaigns were introduced across several media platforms with key messages tailored to meet different audiences.

Quick wins
A particular focus of the programme was to introduce quick win interventions to reduce rates of CDI on five wards / areas with historically high rates of infection, with the number of incidences attributed to these areas subsequently tracked as a percentage of all Trust incidences. Key interventions include improved awareness with staff, patients and visitors, timely isolation and side room oversight, and increased hand hygiene and IPC compliance.

Cleaning
Alternative cleaning equipment – flat mops and products – hypochlorous acid have been trialled on one of the focus wards (Ward 36) to test the impact on standards of cleanliness and hygiene. As the pilot comes to an end, Ward 36 continues to record rates of CDI.

Antimicrobial stewardship
Antimicrobial stewardship continues to be a key factor, with the recommendation approved for procuring smaller pack sizes of co-amoxiclav in ED to promote optimal course length prescribing for take home medicines. Packs have been ordered by procurement team and are due to be implemented in February 2025. Further approval is being sought for the acquisition of 5-day prepacks of amoxicillin, doxycycline, clarithromycin & metronidazole.

PSIRF
The Rapid Evaluation of Care (REC) process has been recently reviewed, with a more succinct rapid review introduced. Terms of reference and a proforma have been

developed with the process resulting in supported learning and prompt intervention. This process is to be evaluated further in February 2025.

Showcase event
A Showcase event was delivered Trust-wide in November 2024, with staff involved sharing proven quick win interventions introduced, with a view to adopting these Trust wide, alongside reaffirmation of best practice as defined by Infection Prevention and Control Policies. These key messages were captured as part of a *Clostridioides difficile* Change Bundle, designed to support teams with introducing these interventions across their areas.

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.

The Trust fully transitioned across to Learning from Patient Safety Events (LFSPE) In September 2023 this is now the first full year that we have been reporting into LFPSE. 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. Work is currently ongoing with NHSE who are creating national data Dashboards to be able to report from.

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.

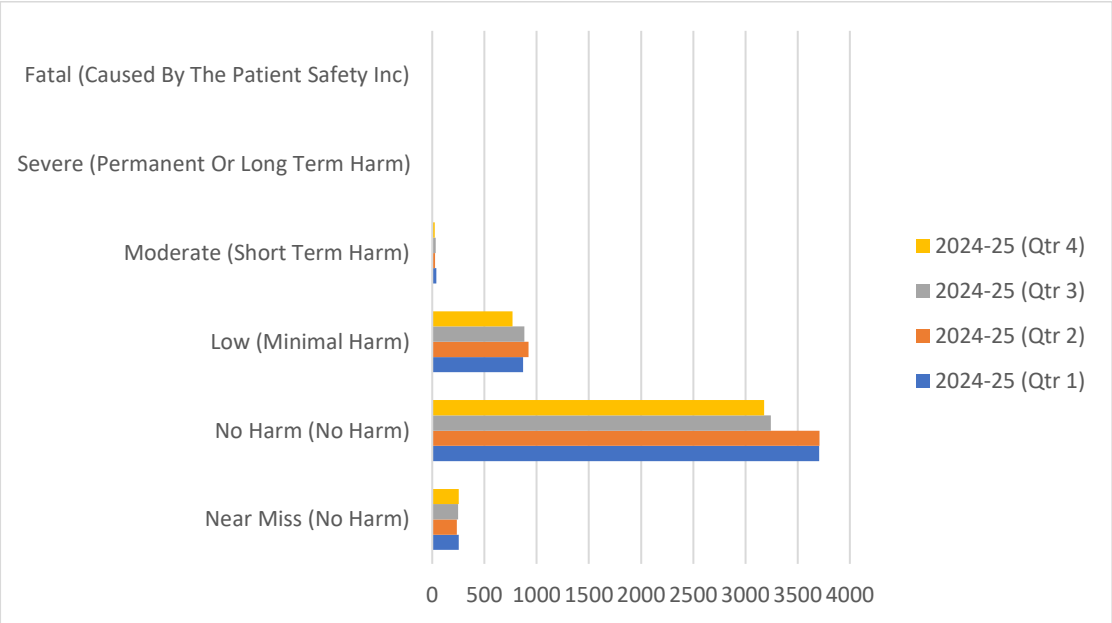
The data below is the latest published date for 2024/25. In this reporting period the Trust only reporting into the LFPSE. This data has been validated by the LFPSE and each patient safety incident is reviewed for accuracy during its clinical managerial review.

	2024-25 Qtr 1	2024-25 Qtr 2	2024-25 Qtr 3	2024-25 Qtr 4	Grand Total	Percentage
Near Miss (No Harm)	253	236	247	254	990	5.12%
No Harm (No Harm)	3705	3709	3244	3178	13836	71.64%
Low (Minimal Harm)	870	922	881	768	3441	17.82%
Moderate (Short Term Harm)	38	27	34	24	123	0.64%
Severe (Permanent or Long Term Harm)	4	4	4	3	15	0.08%
Fatal (Caused by The Patient Safety Inc)	2	1	2		5	0.03%

From 1st April 2024 – March 31st, 2025, there was a total of 19413 incident reported to LFPSE.

Under the Patient Safety Incident Response Framework (PSIRF) there were 5 Patient Safety Incident Investigations (PSII) initiated, during this period the Trust reported zero Never Events.

The trust has embedded PSIRF and has really focused on the learning, over the last year everything we have learned from doing PSIRF investigations we have decided to relaunch the way in which we investigate and report, with plans going into 25/26 financial year to improve on how we currently undertake PSIRF. An audit of PSIRF in the Trust was conducted by MIAA, which provided substantial assurance.



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 30 September and 28 November 2024. 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 for areas that were identified by Divisions as may benefit from a paper version.

We had a 47% response rate this year, with 3,128 staff completing the survey. Whilst this is just below the Acute and Community & Acute sector average of 49%, it is significantly higher than last year (38%).

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 2024 Score	National 2024 Comparator Average	Statistically significant Change from 2023?
We are compassionate and inclusive	7.14	7.21	No
We are recognised and rewarded	5.71	5.92	No
We each have a voice that counts	6.46	6.67	No
We are safe and healthy	5.91	6.09	No
We are always learning	5.38	5.64	No
We work flexibly	6.07	6.24	No
We are a team	6.62	6.74	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 2024 Score	National 2024 Comparator Average	Statistically significant Change from 2023?
Engagement	6.56	5.66	Yes
Morale	6.84	5.93	No

The Trust scores slightly below average in all areas, with no statistically significantly change, except for the staff engagement score which has unfortunately reduced this year.

Feedback also highlights:

- There is more compassionate leadership.
- Immediate managers care about concerns.
- Staff feel they are able to openly discuss flexible working opportunities.
- Staff feel less burnt out.
- Managers are more encouraging and give clearer feedback.
- Fewer staff are experiencing bullying/harassment.
- Of those that have experienced it, more are reporting it.
- More reasonable adjustments have been made to support staff in work.

Areas for improvement are:

- Staff engagement.
- Challenges in meeting demand.
- Violence and patients displaying challenging behaviours.
- Staff confidence that issues raised are listed to and addressed.
- Staff's ability to influence positive change in their area of work.

On review of survey findings, the following areas of focus are proposed for 2025/26:

1. Improvement for All: *empowering staff to create change*
2. Staff Safety: *reducing violence and challenging behaviour*
3. Reporting Concerns: *improving staff confidence*

The 2024 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.

Workshops have been undertaken to share findings, support understanding of data and to identify focus areas and inform plans for 2025/26 for Divisions, Corporate Service Heads of Service, subject matter experts and key enabling strategy leads.

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. Additional workshops are also being implemented to focus on key areas including speaking up / raising concerns and to understand experiences of staff who share protected characteristics.

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:

- Implement phase one of the new Cority IT system

- Improved Occupational Health referral to treatment times and health report turnaround times.
- Increased psychotherapy capacity has been established to support staff.
- Responsive psychotherapy for staff in reaction to event inside and outside of the Trust
- Listening events within Women and children's division
- Mental health first aid training continue and support events organised for trained staff
- MIAA audit into wellbeing gave substantial assurance with 3 actions regarding comms and one policy update
- 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.
- Virtual Occupational Health nurse Drop-in clinics
- Vaccination clinics to tackle emerging public health treats i.e.- pertussis
- 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.
- Reward and recognition awards for staff
- Breakfast with Chief executive and other member of the exec teams
- 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.
- ON site EAP presence quarterly in staff areas
- Achieved SEQOHS annual re-accreditation.
- Wellbeing walks during ongoing industrial action by service leads and professional nurse advocates (PNAs).
- Extra counsellor sessions via Red Poppy to support staff where required.
- 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.
- Talking Together Wirral with regular on-site presence in the patient experience HUB
- Staff Zumba sessions re launched/advertised

- Winter vaccinations programme
- Wellbeing Garden in Clatterbridge hospital
- Winter Wellbeing comms plan- 'countdown to Christmas'
- Comms campaign to re advertise how to self-refer into Occupational health and physiotherapy and how to make a good Occupational health referral
- ICB funded and produced digitalised document to sign post managers and keep details on how to make a good Occupational health referral in development
- MPOX plans for Occupational Health and staff risk assessments
- Health and wellbeing pages updated on the intranet
- Focused vaccination clinics in APH site
- Return to work guidance for respiratory infection reviewed and published
- Signed up to the Sexual Safety Charter
- Awards Bronze for antiracism charter??/

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.

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:

- Continue to produce plans for the Occupational health Department in alignment with the Grow OH strategy
- Phase two of the Cority system to be launched providing staff and managers an online portal
- Occupational Health Nurse led drop-in sessions.
- One Wirral CIC performing health check to staff starting with Estates and Facilities
- Quarterly Wellbeing surgeries to have a focus on both physical and mental wellbeing.
- Psychoeducation session to tackle stress and anxiety
- Neurodiversity drop-in sessions for staff ran by the sunflowers network
- Free menstruation products for staff

3.2 HSJ Awards – Trust of the Year Finalist

WUTH were shortlisted finalists in the Health Service Journal (HSJ) Awards for Trust of the Year. This is a real testament to all the hard work and tireless dedication of everyone. The Trust has undergone an unprecedented transformation programme in recent years. We have delivered capital projects to enhance patient care, including the new Cheshire and Merseyside Surgical Centre. We have been one of the best performing Trusts for elective recovery in the North West.

We also achieved national Getting it Right First Time national NHS accreditation for the high standards of clinical and operational practice at our surgical centre. We now have two diagnostics centres at the Clatterbridge site, the first of which has carried out over 100,000 diagnostic tests since it opened in 2021 and the second centre opened in April this year with a new MRI and CT scanner, enabling earlier diagnosis for patients. As a Trust we have also excelled in cancer treatment waiting times, achieving the 28-day faster diagnosis standard at the end of March 2024. The new Transfer of Care Hub has dramatically reduced the number of patients in our hospitals who don't meet the criteria to reside, ensuring patients are home as soon as they are fit and well.

As you are aware, our Maternity Services were rated as Good with areas of Outstanding practice in the most recent CQC inspection. We have a comprehensive People Strategy focused on making the Trust a great place to work.

A new Patient Safety Incident Response Framework has also been introduced along with a daily Safety Huddle and forums around lessons learnt, to enhance patient safety.

The Research Team has conducted over 72 studies, recruited 488 patients, with 68 research active clinicians. One initiative is our award-winning work with Marine Lake Medical Practice on a ground-breaking study looking at how babies can be protected from RSV infection.

These are just some of the many initiatives that we can be extremely proud of and for which we are deserving of being announced as finalists in for Trust of the Year in the HSJ Awards. Janelle Holmes, Chief Executive, said: "Real transformation work has been carried out by teams across our hospitals and I would like to say a big thank you to all our staff. Everything you do to improve our hospitals has a direct positive impact on patient care. I'm delighted we have been nominated as finalists in the HSJ Awards and mostly I'm extremely proud of everything we have achieved together over the past five years."

3.3 Silver Award in the Defence Employer Recognition Scheme

At WUTH, we proudly support the defence community through our commitment to the Armed Forces Covenant, and this year, we've been recognised with the Silver Award in the Defence Employer Recognition Scheme. This award highlights our dedication to creating an inclusive environment that values the contributions of former and current service personnel.

3.4 Blood Order Rationalisation Project

a) Impact of implementing duplication rules in Cerner Millenium for Pro-BNP tests

- Data analysed for completed Pro-BNP lab orders between November 2022 and June 2024
    - All encounter types in the Trust included.
    - Primary Care, GP orders were excluded.
- Trend results clearly show a decline in orders place following implementation of duplication rules, equating to a 37% activity decrease on the previous 3-monthly average.

b) Financial Savings

- Comparing 3months worth of pre-change activity & spend with 3months worth of post change activity and spend we find £40,094.08 worth of saving for the year.
- This equates to an actual reduction of 31.27% against our predicted 30%.
- These costs are based on the test unit price alone and do not include staff and other related costs.

3.5 Ward Accreditation

WISE (W – Wirral, I – Individual, S – Safe Care, E – Every time) ward assessment and accreditation programme has been in place since 2019. The WISE programme focuses on delivering high quality individualised, safe care to patients, which is a key priority for the Trust.

The table below demonstrates the progression of ward accreditation attainments comparing levels of assessment at implementation in 2019 to levels achieved in 2024.

	1st Audit Cycle - 2019		Current Audit Cycle - 2024	
Levels				
Level 1	10	37%	1	3.22%
Level 2	16	59.3%	7	22.5%
Level 3	1	3.7%	23	74.19%
Total Areas	27		31	

The wards that have been reassessed have shown sustainment and ultimately improvement in the care given, with two wards achieving four consecutive Level 3 assessments. Five wards have achieved Level 3 status for three consecutive assessments. The single ward at Level 1 is being supported towards improvement.

Tendable™

Tendable inspections are used to assess quality, safety, and patient experience across our clinical areas providing real time and high visibility assurance.

During 2023 / 2024 the use of Tendable across the Trust has continued to expand with an extended range of audits and increased areas being included: 46, 649 inspections were completed using 104 different audit types across 180 areas. In addition to clinical areas, support services have implemented the use of Tendable inspections such Health and Safety inspections including Quarterly Environmental Risk Assessment.

3.6 Streaming patients from Emergency Department to Urgent Treatment Centre - getting patients to the right clinician first time

A two-week pilot at the end of 2024 whereby WCHC Urgent Treatment Centre staff works alongside ED Triage Nurses to support decision making on streaming patients to the Urgent Treatment Centre. The pilot saw a significant increase in the numbers of patients streamed, therefore reducing congestion and waits in ED whilst ensuring patients are seen by the right clinician in a timely way. Work is ongoing to find a sustainable staffing model to maintain this improvement.

3.7 Establishment of Frailty Same Day Emergency Care (SDEC)

Following a successful two-week pilot on OPAU from 9th to 20th December, the Acute Frailty SDEC service has now been scaled up into a larger, dedicated space — the Acute Frailty Unit — and is now a fully established part of our Urgent and Emergency Care pathway.

This initiative stands as a fantastic example of a co-designed, staff-led test of change, showcasing the power of collaborative working across disciplines. During the pilot, 70 patients were seen, with 47 safely discharged the same day — a 67% same-day turnaround rate. This rapid response model provided timely, personalised care to older adults, avoiding unnecessary hospital admissions while maintaining patient safety and dignity.

Now operating as a standard service, the Acute Frailty Unit continues to offer high-quality, same-day, multidisciplinary assessment and intervention. It plays a critical role in supporting older patients to remain well at home through expert, rapid support — improving outcomes, enhancing patient experience, and optimising flow across the wider hospital system.

3.8 MDT Optimisation

Wirral University Teaching Hospital undertook a Trust-wide review of Cancer MDT meetings to modernise areas that had seen little change over the past few years. The review was driven by national recommendations and a recognised need to improve efficiency, consistency, and clinical impact.

Approach included:

- Stakeholder engagement via surveys, interviews, and direct MDT observations
- Consideration of local, regional, and national context, including best practice guidance and policy recommendations

Key findings

- Strong patient focus across MDTs
- However significant variation in processes, documentation, and meeting efficiency
- Also gaps in referral consistency, use of protocols, and live outcome recording.

Outcomes:

- Development of Trust-wide MDT Standards, covering:
    - Meeting structure and processes
    - Standardised referrals and use of protocols
    - Quoracy, triage, and data capture
    - Leadership, communication, and learning
- Introduction of an annual Gap Analysis Matrix for continuous improvement, overseen by the Trust Cancer Steering Group

This work sets the foundation for safer, more consistent, and higher-quality decision-making in MDTs across the Trust.

3.9 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 resourcing, medical education & the 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. NHSE has set out measures to “Improve the Working Lives” of doctors and has pledged to enhance choice and flexibility with rotas. This is a key priority for WUTH alongside reducing duplication of training, which will free up valuable time for doctors.

Following an NHSE Deanery quality visit in 2024 an action plan has identified a further priority to include clinical input to Rota and devolve some oversight of the Rota to divisions where appropriate, including self-rostering in the emergency department. This work is ongoing and is led by Professor Barrett, the Director of Medical Education.

3.10 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 2024/2025– Performance Metrics		
Performance Indicators	**Target**	**End of March 25**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	80%	57.6%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (Arrowe Park site)	95%	60.7%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge (WUTH ED only)	95%	45.2%
C. difficile: variance from plan	103	167
Maximum 6-week wait for diagnostic procedures	99%	92.4%
Venous thromboembolism (VTE) risk assessment	95%	97.5%

The below table shows the national cancer standard and the achieved percentage for the year 2024-2025. The standard of maximum 14 days from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals was removed from the national cancer standards in October 2023.

National Cancer Standard	Description	National Cancer Standard Threshold	Q1	Q2	Q3	Q4
28 Days	Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	Minimum 75%	76.19%	76.58%	75.82%	71.59%
31 Days	From Decision To Treat/Earliest Clinically Appropriate Date to Treatment of cancer	Minimum 96%	92.46%	90.01%	87.68%	89.26%

62 Days	From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer	Minimum 85%	76.20%	77.61%	76.65%	74.61%

It should be noted that for 2024-2025 the NHSE requirement was (for all trusts) the position for the end of March 2025 for the 28 day standard should be >=77% and the 62 day standard >=75%. The 28 day expectation based on the threshold for 28 day performance moving to be 77% for 2025-2026 with the expectation trusts will be at >=80% by the end of March 2026. The 62 day expectation due to acknowledgement around recovery with the expectation trusts will be at >=77% by the end of March 2026. The trust 28 day performance for March 2025 was 75.18% and the 62 day performance for March 2025 was 77.37%.

The trust has had to submit three recovery trajectories for 2025-2026, as part of NHSE operational planning guidance, which sets out month by month the expected level of performance for 28 day, 31 day and 62 days. The trust has set ambitious targets as follows:

1. 28 day – to achieve 80% by then end of March 2026
2. 31 day – to achieve 96% by the end of March 2026
3. 62 day – to achieve 77.5% by the end of March 2026

Statement from NHS Cheshire & Merseyside Integrated Care Board (NHS C&M ICB) 2024-25

NHS Cheshire and Merseyside

NHS Cheshire and Merseyside has worked closely with Wirral University Teaching Hospital NHS Foundation Trust throughout 2024/25 and recognise the achievements made with regards to quality throughout the year. The Quality Account demonstrates the Trust's commitment to improve the delivery and quality of care for patients and embed a culture of improvement across the organisation.

The Trust has undertaken significant work against the identified 2024/25 quality priorities. Fully achieving one priority around supporting effective communication and accurate documentation during transfer of care and partially achieving the identification of the deteriorating patient priority.

We note your 2024/25 quality priority in relation reducing the rates of Clostridium Difficile (C.Difficile) infection has not been achieved with the number of patients diagnosed exceeding the threshold set out in the 2024/25 NHS Standard Contract.

Although the Trust did not achieve this priority, it is positive and encouraging to see the implementation of the quality improvement and strategic plan taking effect, with a noticeable reduction in the number of C.Difficile cases reported towards the end of the financial year. We look forward to overseeing the improvements in the coming year, in addition to those set out within the 2025/26 priorities.

We congratulate the Trust on being shortlisted as a finalist in the Health Service Journal (HSJ) awards for "Trust of the Year", this is a remarkable achievement and acknowledges the hard work and dedication of the Team.

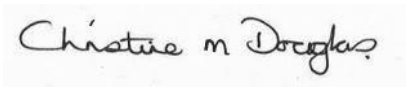
The ICB acknowledge the Care Quality Commission statement published in November 2024 following the focused inspection of Urgent and Emergency Care services. The Trust has taken immediate action and have developed an action plan to ensure longer term actions are implemented, providing assurance actions will be monitored through a robust governance process.

The Trust's active clinical audit programme has been described within the account. The comprehensive improvement plans assure oversight of clinical effectiveness. We will continue to work closely with the Trust to understand the clinical audit findings requiring action during 2025/26 and support this delivery to allow further improvement journeys to be presented in the next quality account.

The Trust continues to demonstrate an open learning culture, particularly focusing on mortality related learning key lessons are shared transparently within the account. We will again work closely with the Trust to oversee the improvements made against these learning points.

Finally, it is recognised that the individual effort of staff and teams within the Trust make a huge impact to patient care. This is recognised though the highlighted awards and achievements noted within the 2024/25 quality account.

Yours sincerely



Chris Douglas MBE
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cc. Kerry Lloyd, Lisa Ellis, Helen Meredith

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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